

THE ROLE OF THE FATHER IN THE LABOUR ROOM: AN EMPIRICAL STUDY

Irene Walton

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Abstract

The part played by fathers in hospital childbirth was investigated over a period of eight months during 1997-8 in a Northern UK hospital using various research methods. Semi-structured interviews were conducted with small groups of expectant and new mothers and fathers, midwives and doctors. Concepts were then developed which formed the basis for a labour room observation schedule. The researcher, a qualified midwife using anthropological techniques, attended the birthing experiences of 15 women in the labour rooms and recorded the movements and interactions in space and time of those routinely present as well as her own. A quantitatively analysable questionnaire was sent to a larger sample of the population, and a schedule was devised and used to interview the directly observed couples some time after the experience and away from the ward. A systematic approach to the analysis produced five overarching analytical categories: alliance formation, supportive championship, protective vigilance, linkmanship, and becoming a father, as useful to provide an initial theoretical framework for analysis. This gave rise to the overall conclusion that relationships, movements and events experienced in and around the labour process were structured by, but also, reinforced complex and sometimes shifting inequalities of power which however had the overall effect of marginalizing fathers who shared less than fully in the total experience. It is suggested that awareness of these apparently fixed cultural, structural and processual constraints could enable those professionally concerned to facilitate the empowerment of women and their partners and at the same time improve their own work experience. The findings suggest that future research might explore the educational, ideological and emotional relationship of midwife, mother and father and the ritual and pragmatic implications of fatherhood, as itself a complex rite of passage, of which presence at birth is only one fraction.

Glossary of Terms and Abbreviations

| | |
|-------------------------|--|
| Cervix. | Lower third of the uterus |
| Gravid | Pregnant (e.g. G2 pregnant for the second time) |
| Maternal Mortality | The maternal mortality rate for any year is the number of deaths attributed to pregnancy and childbearing per 1000 registered total births. |
| Perinatal Mortality | The perinatal rate is the measure of the number of stillbirths and deaths in the first week of life infancy per 1000 registered total births |
| <i>Stages of labour</i> | |
| □ First | The period from the onset of regular uterine contractions, accompanied by effacement of the cervix and dilatation of the cervical os, to full dilation of the os uteri |
| □ Second | The period from full dilatation of the os uteri to the birth of the baby. |
| □ Third | The period following the birth of the baby until complete expulsion of the placenta and membranes. |
| Para | Having borne a child (e.g. G3p2 having borne two children and pregnant for the third time) |

Internal and external openings of the cervix

| | |
|------|---|
| MW | Pre-observation interviews midwife |
| Dr | Pre-observation interviews doctor |
| EF | Pre-observation interviews expectant father |
| NF | Pre-observation interviews new father |
| NM | Pre-observation interviews new mother |
| PW | Pregnant woman |
| FN | Field notes |
| Obs. | Observation in the labour ward/room |
| PO | Post delivery interviews |
| FG | Focus group |
| Q | Response from questionnaire (numbered) |

Preface

State Power

"Power has to do with whatever decisions men make about the arrangements under which they live, and about the events which make up the history of their lives. Events that are beyond human decision do happen; social arrangements do change without the benefit of explicit decision. But in so far as decisions are made, the problem of who is involved in making them is the basic problem of power. In so far as they could be made, but are not, the problem becomes who fails to make them?"

Wright Mills (1967 p23)

According to Wright Mills (1967) there are at least three types of power. They are, authoritative, that which is justified by the beliefs of the voluntarily obedient, manipulative, that which is wielded unbeknown to the powerless and coercive whereby power is exerted overtly on the powerless.

In the United Kingdom Her Majesty's Government is the seat of authority and it has the power to make decisions of national and international consequence on behalf of the state. Although it can be argued that some of the decisions that are made can affect institutions such as the family in a manipulative and even coercive manner the actual power can be simplistically (albeit disputably) considered to be given to Parliament by the people. This makes the 'people' powerful and the State's power authoritative. The State (the body politic) requires that its objectives in the political, military and economic areas be met. In order to do so it needs a healthy population and this is monitored by its various bodies such as the Department of Health, and its success is published in league tables by the Office of Population, Censuses and Surveys (O.P.C.S.). The stability of the body politic, as Scheper-Hughes and Lock (1987) point out rests on its

ability to survey and to regulate populations (the social body) and to discipline individual bodies. This surveillance is achieved in the modern era through what Foucault (1980, 1991) termed 'the Gaze'.

One of the factors under constant consideration is the perinatal mortality rate, which is then compared with that of other developed countries to give an indication of Britain's relative standing. One of the desired outcomes of maternity care is a low mortality and morbidity rate for both mothers and babies. To this end the maternity services are either delivered through the government's instrument, the National Health Service or in a minority of cases through private institutions which are strictly controlled and regulated. Legislation is put in place by means of which all aspect of provision and providers can be regulated. These include regulation of professional education, resource allocation, quality initiatives and managerial structures. Government policies are devised and developed more often than not by Select Committees such as that chaired by Winterton (House of Commons 1991-92) These in turn seek evidence from and are advised by the various health professionals such as obstetricians and midwives as well as lay people. Midwives and obstetricians have conducted a struggle for professional control over childbirth that is well documented (Donnison 1988, Garcia 1990 Tew 1995). It is probably true to say that the doctors have won the contest and are the dominant profession. They have achieved and maintain their superior position through the mechanism of authoritative power i.e. higher education, symbolic appearance, (white coats and use of artefacts) and society respects their objects and perceived objectivity. This being so they are more likely to be heeded at national level and their biomedical model of care more likely to be the prevailing system within the maternity unit setting. There are other advisory bodies such as the Standing Nursing and Midwifery Advisory Body (SNMAC) which report on health from a nursing and midwifery viewpoint. However the major challenge to the doctors'

position now comes from another male dominated profession, health service management, which acts in pursuit of economic aims rather than on philosophical grounds.

Women who are the bearers and chief carers of children, (who in turn will be the State's future workers and fighters) must meet the State's approval. Several writers (Ortner 1974, Ardener 1975, Moore 1988, McNay 1992) have pointed out how problematic this is to society because of the perception and belief that women are, as Ortner puts it symbolically nearer to nature than culture. Nature is uncontrolled and must be regulated by culture, which is seen to be superior to the natural world.

"Since culture seeks to control and transcend nature, then it is 'natural' that women, by virtue of their close association with 'nature', should also be controlled and contained".

(Moore 1988)

In order to gain particular objectives, the State use its power for the social construction of motherhood. These objectives have changed several times over the past fifty years. During and immediately after the Second World War mothers were exhorted to leave their children in day nurseries and to work outside their home. Later, in the 1970s and 1980s, they were made to fear the spectre of 'latch-key kids' and encouraged to stay at home. The latest view of an acceptable mother is someone who is economically supported and who breast-feeds her baby. She is encouraged in this by the granting of maternity leave, maternity pay and the direct payment of child benefit. There is also a move to reduce the number of unsupported and teenage mothers and economic sanctions and incentives to work are being directed towards them. Maternity units are devising policies which aim to improve breast feeding rates and the Government is considering a new 'carrot', a monetary grant of up to ten pounds a week which has to be spent on healthy food (RCM 2000).

Fatherhood as a social construction has not been as much of a concern to the state as has motherhood. However because the Government want mothers to be supported there are new initiatives afoot to strengthen marriage and to make fathers more accountable. Coercive measures are used to ensure that even absent fathers contribute to their children's upbringing. One such measure is the Child Support Act (1991) that enabled the setting up of the Child Support Agency (CSA) which has far-reaching statutory powers to ensure payments are calculated and taken at source from salaries and wages. In addition to direct pressures there are also incentives and subtle pressures for men to become involved in family life. These include paternity leave arrangements and activities such as parentcraft classes and a direct role model in the new dad, new man look of the current (2001) Prime Minister Blair himself.

Because the power of the maternity service providers is legitimate in that it is derived from the Government and so indirectly from the people it is tempting to think that it is unchanging. If this is the case it would have implications in that internal decisions regarding the care given to women would always be in the hands of the health professionals and external decisions would be changed only through the usual political routes. However as Foucault's work shows (1983, 1991) power is not a constant unless there is no freedom. Where freedom exists there is always a power relationship and within a power relationship there is always potential for struggle, movement and ultimately a power shift.

An Overview

Within the labour ward there exists a society, which is unique, bounded and almost self contained. Functioning within it, at home so to speak, is a core staff of midwives, doctors and healthcare assistants. There are also other health professional staff members such as community midwives, student midwives and medical students who are there on a

long or short-term temporary basis. The labour ward can be viewed as a small-scale society and as such has its own customs, rituals, rules, values and acceptable behaviours which give meaning and order to the working lives of the people within it. It has a culture of its own. The women in labour and their partners and relatives are passing through this society and are found to be marginal. The women are the object of the care process which is (according to the rhetoric) woman-centred and dedicated to giving 'informed choice' (Dept of Health 1993) and their presence is the crucial factor without which the staff's 'raison d'être' would cease to exist. However their partners and relatives have a much newer and perhaps more fragile right to be there.

In order to understand what the role of the father is one could possibly take a theory and apply a research method that has been developed for such a purpose but this could be quite narrow and result in a one dimensional representation. Human behaviour is based upon cultural beliefs, social meanings, attitudes, motivations and intentions. It can change from context to context and from person to person and the same person can act differently at different times. There is probably no such thing as truth to be discovered or an accurate picture, for the social world is not changed by causal events affecting universal laws.

There is also the problem of the researcher's perspective and power for as Layton (1997) says about ethnography from his postmodernist viewpoint:

"Ethnography has usually been written by the dominant about the weak and the practice of translation confers power. When the anthropologist chooses what to render meaningful or rational about another culture (s) he is using that power."

Layton (1997) page 213

The object of this research is to gain as much understanding as possible and needs to use an approach that is broad, reflexive and multifaceted. It must enable the voices of the participants to be heard and to gain

provisional knowledge that can be triangulated to give an opportunity for validation. Because of the nature of the study it is envisaged that both qualitative and quantitative methods will be helpful.

The Beginning

The beginnings of the research go back to the late 1970s. As a new midwife to a particular hospital I was shocked at the antagonism that was shown by some (and I stress only some) of the midwives towards men in the labour room. Unfortunately although they were in a minority they were in positions of power and they were able to develop and implement policies and procedures either formally or informally, which disadvantaged men. One of these was that the midwives were instructed to discourage or even to forbid the father to stand whilst his baby was being born. The motives for doing so were deemed (by those issuing the instructions) to be moral and pure because it was suggested that men had prurient sexual motives for looking at their wives in that position! I am a married woman with two (now grown up) children and, at an earlier period, when our daughter was born in 1967, my husband had been excluded not only from the labour ward but from the maternity home itself. His delight at being a father was something that transformed his life and when I later gave birth to our son in 1970 at home it seemed the natural thing for him to be present. He was supportive to me and overcome with a long lasting and deeply felt joy.

Based on this deeply personal and overwhelmingly satisfying experience I found myself in complete opposition to the ideas proposed by those midwives. At the time I did what was within my power and many years later published my thoughts about the issue of sexuality in the labour room (Walton 1994). Prior to this publication I had qualified and was practising as a midwifery lecturer and entered the MSc in Medical Social Anthropology programme at Keele University. An off shoot of my thinking about fathers in the labour room was an interest in the power structures

inherent in the delivery of maternity care and so I studied the role of men in the labour room for my dissertation (Walton 1993).

The 1993 study was written from a feminist perspective with the emphasis on the effect of men as whole, not just fathers, on women in the labour room. I focused particularly on power structures and their effects. I was concerned that women would find themselves greatly disadvantaged in labour, if surrounded by men. In the event I found that on the surface, at least, this was not the case. However the whole situation was organized in such a hierarchical way that the exercise of covert or subliminal control over the women was nevertheless paramount. I also found that the fathers were as, if not more, marginalized than were the women in labour. The effects of patriarchy and power struggles between the competing groups of professionals in the labour ward have, of course, now been well-documented (Oakley 1984, Donnison 1988). I therefore decided to concentrate on the role of the fathers in the labour room and their relationships and associated behaviours, and to study this phenomenon for my Ph.D.

Introduction to the thesis

The overall aim of the study was to investigate the role of the father in the labour ward. I was interested in particular with the right, if any, of the father to be there, whether or not he was accepted, and how he was supposed to behave and what duties he was expected to fulfil. I was also interested in his support function as seen by himself, his partner and by the midwives and doctors who worked on the labour ward. Initially I conducted a comprehensive literature search and from this I discovered that there seemed to have been two major paradigm shifts in the theories about the optimal care of women in labour. The first was the almost complete move from home to hospital confinement and the second was the admission of men as the main companion to the woman in labour.

There is a great deal written (Tew 1995, Donnison 1988, Oakley 1986) about the 'how' of the move into hospital but little (except by Davies-Floyd (1992) in the USA) regarding the cultural acceptance of this move by women. The literature dealing with the father as a companion to the woman in labour concentrates mainly on his function rather than the meaning of the experience to him. It also showed that there was very little written about the role of fathers in the labour ward and what was available showed discrepancies in the views of the writers. From this search I identified five main functions that I describe in chapter one and consider as foreshadowed issues.

Using an ethnographic approach I aimed to look the expectations of the fathers, the mothers and the health professionals and to observe the interactions between them. I hoped to identify the role performance of the fathers, the support required by the mothers and that of the expectant fathers whose partners were giving birth.

I identified foreshadowed issues prior to collection and analysis of the data, by conducting a literature search before entering the field. I also collected much data prior to detailed analysis. However, I was reflexive and theoretically sampled the actual data using the analytical methods of Glaser and Strauss (1967) and Strauss & Corbin (1990).

I undertook a series of interviews with fathers and mothers (both expectant and newly delivered), and midwives and doctors. In addition I formulated questionnaires and from them I identified concepts, categories and issues that I explored further. This was done by the development and distribution of quantitative questionnaires, ethnographic fieldwork and post-observation interviews with the couples that had agreed to my presence in the labour ward. The quantitative questionnaires resulted in ordinal data, which was then analysed using the Statistics Package for the Social Sciences (S.P.S.S.) computer package. Means were examined and significant differences within and between groups were identified using the one way ANOVA and Tukey HSD tests.

During the course of this research it became obvious to me that the role of the father in the labour room was dependent on many factors not least of all the relationship between the father and his partner and the women's need for support. As the time went on it became obvious that the father's competence at supporting his partner depended very much on the prevalent power relations, his ability to ascertain the situation, comply with the rules and make allies of the midwives. It was useful to look at role theory, infantilization and Foucault's concepts of power relations to make the data meaningful for practice.

I reflected on the whole process and identified the limitations of the methodology and the tools I developed and used. I discussed the research process and the generation of concepts and categories. The theoretical framework was identified as a story line. Following this I identify the power issues, implications for practice and make recommendations for future research.

Organisation of the Thesis

I have organised the thesis into the following chapters,

Chapter One. Fore shadowed Issues from the literature

In this chapter I review the literature starting with a look at the history of having a baby in this country and how there has been a paradigm shift in the culture of women's birthing experiences. This has changed from nearly 100% home confinement to almost all hospital births. Men's entrance to the birthing room is charted and their role and function explored with particular emphasis on the support function, gap filling, mother's advocate and team member roles. The concepts of at risk woman and men and invisible women and men are considered. The chapter concludes with a consideration of social support outcomes.

Chapter Two. Methodological and Ethical Considerations

In this chapter following a consideration of various methodologies I describe my concerns with potential problems and describe my methodological choice. In the event I chose a mixed methodology incorporating both qualitative and quantitative methods. I used preliminary unstructured interviews, ethnographic fieldwork observations, structured questionnaires and semi-structured interviews. Potential ethical problems were considered and the underpinning theory was carefully thought about. They are utilised to forestall problems. Issues of informed consent, privacy, confidentiality, gatekeepers, and the right to withdraw from the research are discussed. I then identify the research question and aims and describe the sample size

Chapter Three. Context

This deals with a description of the context itself. It starts with a description of the hospital and the way that a couple would progress from the outside past the gatekeepers and into the inner sanctum of the labour room itself. I then go on to show how the couple are institutionalised. I look at the issues of privacy, and how the design of the labour ward and set up of the labour room itself, has a part to play in such regulation.

Chapters Four. Beliefs and Knowledge

In these chapters I analyse the belief systems of the fathers, the mothers and the health professionals. I deal with the knowledge that people have and the ways in which they acquire and value it. Both the men and the women's beliefs are inextricably linked to such factors as social duties, obligations and responsibilities and are acquired as cultural and gender ascribed determinants. The midwives and the doctors' beliefs are acquired in part by their socialisation into the profession and by the concepts of the dominant knowledge base.

Chapter Five. Opinions

Prior to the observational part of the study I had developed a quantitative questionnaire which was sent out to expectant fathers and mothers, new fathers and mothers, midwives and doctors. This chapter presents the

meaning of the results. I draw conclusions from the six sections of the questionnaire which centre on the presence and role of the father, the context, education for labour and birth, gender issues and personal information. These are discussed as the opinions and expectations of the various respondents.

Chapter Six. Power, Compliance and Alliance

In this chapter I deal with the concept of power and how this is transmitted by the design of the labour ward, artefacts, and symbols. Foucault's (1980, 1991) concept of the 'gaze' is discussed, particularly in relation to the role of the professional groups and their policies, protocols and working practices. The power of the mothers and fathers over the environment of care was shown to be limited and in the case of the fathers tenuous.

Chapter Seven. In the Birthing room

Here the process of birth and the activities of the man as he becomes a father are examined. I explore the frames of behaviour as described by Goffman (1974) and Peräkylä (1989) and show how the midwife moves between two frames of them, the medical and lay, but in each of which she is higher in authority than the woman and her partner. I analyse the transcripts of the observations that I made in the labour ward and labour rooms. Using a WinMax Pro computer package I employ a systematic approach based on Strauss & Corbin's (1990) work and discourse analysis (Silverman 1993) to identify the concepts from the data, the phenomena and finally the overarching categories that can explain the role of the father in the labour room.

Chapter Eight. Follow Up

Following the births I interviewed ten couples in their own homes. The interviews were taped and transcribed. The transcripts were analysed using the concepts and categories that had been developed previously. In addition my understanding of the meaning of observed behaviours was checked against the participants explanations. The overarching categories were examined for sufficiency and inclusiveness.

Chapter Nine. Reflection

This, the final chapter discusses the limitations of the study from methodological aspects to weaknesses or limitations with the tools used. The research questions are revisited and the findings discussed in the light of the questions. The concept and category generations is detailed and the theoretical framework shown as the story line. Role theory, Turner's work on liminality and rites of passage, and Foucault's work on power relations, struggles and shifts are used as the basis for analysis of the effects. Implications for practice are discussed and recommendations for further research are made

Chapter One. Foreshadowed Issues from the literature

Introduction

In most cultures pregnancy and the birth of a baby has been a predominately female event with the father playing a minimal and functional role (Heggenhougen 1980). Until the late nineteenth century birth in this country took place mainly in the home and it is thought (Mitchell 1982) that when a woman went into labour she called her woman friends and relatives who made most of the birth arrangements. It is likely that these would include blocking up of all crevices including the doors and the windows to keep out draughts that could cause the flux (Carter & Duriez 1986). The fire would be built up and a warm enclosed space was formed (which could possibly have become very stuffy and added to the woman's discomfort). Apart from making the room warm, this practice is thought (Carter & Duriez 1986) to have originated in the desire to keep the woman safe by preventing the entrance of evil spirits. This was perhaps because although birth is a normal life event it seems to have been less safe than today. For example the national maternal mortality rate for the years 1847-1854 was 5.4 per 1000 (Tew 1995 p201). In comparison for 1994-96, the total number of maternal deaths including direct and fortuitous for the whole of the United Kingdom was 376 women (DOH 1998). Records were not kept of perinatal deaths until later than 1854 but the perinatal mortality rate for 1896-1900 was 156 per 1000 compared with 8.2 per 1000 for 1998 (DOH 2001a). It seems (Gelis 1991) that the father of the baby was very often the person who took the main responsibility for the blocking up of the crevices and although it was perhaps not an act of overt couvade, it can be linked to this because as Munroe et al (1980) say,

“Ritual couvade is generally regarded as prosocial behaviour signifying magicoreligious protection for the infant and the mother.”

These female relatives (Gelis 1991) would probably talk and recall their own deliveries, gossip and comfort (or scare) the woman in turn. It was generally considered to be women's space and if a midwife was in attendance she was more often than not a woman although *‘from the 1720s onwards, more and more men were coming into the field’* who were more inclined to use instruments (Donnison 1988 p34).

“Calling on outside help only slowed the labour down by its psychological effect on the woman’ and a mere mention of forceps ‘triggered a panic reaction’

(Gelis 1991).

It is thought that the father was usually supported by other relatives or friends in another part of the home and entered the birthing room after the baby was born and bathed (Chapman 1991). There are many woodcuts extant which show the woman in labour and they very often show her surrounded by other women but few if any men are ever shown to be present e.g. frontispiece of *Midwives Chronicle* (December 1982)

During the last one hundred years birth has increasingly taken place in hospital with an associated increase in the presence of men. With the arrival of antenatal care and associated procedures this was initially mainly as general practitioners or obstetricians rather than husbands and partners. In 1919 following the First World War and the massive influenza pandemic the Ministry of Health was established with a separate department for maternity and child welfare. The Senior Health Officer Càmpbell ordered a series of investigations into various aspects of maternity care including training of obstetricians and midwives and maternal and infant mortality. The results showed that women were at most risk from incompetent practitioners e.g. manual interference, and less from insanitary home conditions (Campbell 1924). However the

recommendations which were aimed at *“the establishment of a comprehensive and efficient maternity service”*, enabled the local authorities to upgrade and expand obstetric and gynaecological units and by extension increase the number of labour beds.

Following World War II, in 1946 the Population Investigation Committee in collaboration with the Royal College of Obstetricians and Gynaecologists (R.C.O.G.) carried out an inquiry into pregnancy and childbirth as a preliminary to restructuring the health service (Tew 1995). They found that, although the risk of booking for a home confinement (including transfer) was less than for a hospital booking, and, although women preferred to deliver at home, they recommended *“there is a good case for the encouragement of hospital delivery”* (R.C.O.G. 1946). This seemingly arbitrary decision made by a group composed mainly of men not only served to possibly disadvantage women, but also to further distance fathers from the whole event by institutionalising it. This trend, although based on unsubstantiated evidence continued throughout subsequent Government reports e.g. The Guillebaud Report of 1956 (Ministry of Health 1956) which advocated a 50% hospital bed provision and the Cranbrook Report Of 1959 (Ministry of Health 1959) a 70% target. Then came the Peel Report of 1970 (Ministry of Health 1970) which went the whole way and said all births should be in hospital. This stance was reaffirmed by the 1980 Short Report (House of Commons 1980) which went further and recommended that hospital labour wards should be staffed and organised like intensive care units. The next major look at the maternity services resulted in the Winterton report (House of Commons 1990 –1991) which was more evidence based and insightful with a wider ranging view and was outspoken in the need for a more humane approach to maternity care.

The effect of all these reports is seen in the 98% hospital delivery rate (Tew 1995). ‘Changing Childbirth’ the report from the Expert Maternity

Group (Dept. of Health 1993) set up as part of the Government's response to the Winterton report did not actually call for a reduction in hospital beds and a return to home confinement but did say "*women should be given clear unbiased advice*". This particularly emphasised the need to "*ensure real choice about place of birth.*" (Dept. of Health 1993). Whether women do receive such advice is debatable but is not the focus of this work. Women in the main now have their babies in a hospital or maternity home setting and now can be accompanied by their partners if they so wish.

With the increase in hospital births has come the presence of more men although midwives are the most senior people at approximately 70% of births (DOH 1993). The culture for labouring women seems to have thus changed dramatically in approximately four generations. At first in hospital confinements the woman was often forbidden companions and so laboured alone (A.I.M.S 1961). With the rise of the feminist and natural childbirth movements (Antle-May 1985, Perrin 1985) and women's increased economic and personal autonomy (Paige and Paige 1981) there was an ever-increasing call for the right of women to have a companion of their choice. These were in the face of some early, negative reactions from the health professionals, for example, it was postulated that infection rates would increase (Alexander 1972) or that the men would faint and become a burden (Morton 1966). Another negative reaction was one that Kirkham (1987 p51) entitled 'sadistic observer'. She exemplified it by the quotation (amongst others) from Mathews (1961) who interpreted some fathers' desire to be present only at the birth as "*giving support to the opinion that the underlying motive is one of curiosity rather than a desire to support a labouring wife.*"

This viewpoint changed somewhat over the next two decades until fathers were viewed as '*dispensable supporters*' (Kirkham 1987). However despite Government reports and directives there may still be a negative but covert undercurrent of antipathy towards the presence of the father in the labour ward.

The Companion

In Western countries according to the World Health Organisation study (WHO 1986) the father is present during labour in 12 out of 23 countries and this is likely to have increased in the last decade. In England according to a Royal College of Midwives (RCM) survey of fathers, 98% of the respondents (n = 441) were present during the labour and 85% watched the baby being born (MacMillan 1994). The culture of women's birthing experience has changed from a mainly female dominated event to at least a gender-shared affair. There still appear to be areas of gender based conflict between users and providers of maternity care (Oakley 1984) and between midwives and doctors (Witz 1992) which may help to create and maintain a patriarchal power base. This is despite the Government's stated commitment to making the birthing process as woman-centred as possible (DOH 1993). So in theory if woman-centred care is currently being provided then the woman's wishes regarding the number and type (i.e. male, female, relative or friend) of companions should be respected. Nevertheless it is still normal practice in some hospitals to restrict the number of companions in the labour ward (local hospital policies). This companion as the RCM survey shows is more often than not the father of the baby.

The companion's function

As fathers according to MacMillan (1994) wish to be there (or their partners want them to be) it is worth considering their function. The literature identifies at least five aspects to their role. These are, to

positively enhance the experience of the labouring woman (Perkins 1980, Kirkham 1987, Keirse et al 1995), fill the gaps left by busy staff (op. cit.), and to provide mainly emotional support (Roeber 1987). Also to act as an advocate for the woman (Barbour 1990), and act as a subordinate, well-behaved member of the team in order to help control the mother (Kitzinger 1991).

Social Support Function

To positively enhance the experience of the labouring woman is a social support function that has at least two elements (Turner 1992). The first is the perceived availability of support that may or may not exist in fact. The essential factor is the perception of individuals that they will be supported by others if the need arises (Perkins 1980, Keeling et al 1996). This may be one of the main reasons that women want their partner with them in labour. The second element is the behavioural aspect, the actual or received support which is provided in various forms i.e. the giving of support in response to specific needs (Dunkel-Schetter & Bennett 1990). This behaviour according to Chapman's (1992) study of 20 men is either one of three types. These are coach, team-mate and witness respectively. A coach is a man who has a strong need to be in control of both himself and his partner. A team-mate is one who helps his partner throughout labour in response to requests for support. The witness is one who considers his function to be a companion giving emotional and physical support. For men to function well as support givers they must be able to recognize the need for and be equipped to provide the support.

Work in this area has been done by Perkins (1980) and Kirkham (1987). Perkins says that there are differences such as personality types that may aid or hinder the giving of help and support. Although she maintains that *"no one can teach a man what sort of conversation will be appropriate to his wife's needs"* (page 22) she considers that the midwife can help the man to support his wife in three key areas. These are physical contact,

basic nursing care and pain relief. These she thought were informed by trial and error or imitation teaching, direct instruction or prior to labour at antenatal classes. Perkins advocates a greater attention to the basic issues of courtesy and facilitation of men's learning. Kirkham (1987) pointed out that there were barriers working against men supporting their partners not least of which, were issues of territory and power.

A counteraction to the father's presence in the labour room is made by Hall (1993) who polemically *"challenges the belief that men must participate in this great event"* because she maintains that no one can prepare the man and the woman for what may happen in the labour room. This, if it is true, means that parentcraft classes and preparation for labour are a waste of time. This is at odds with the findings of Lowe (1995) who reported from her study of 485 women that self efficacy scores (the confidence of a woman in her ability to use specific coping behaviour during labour) improved by verbal persuasion from childbirth educators. Other positive outcomes from childbirth education include Moore's (1983) findings, from her longitudinal study of 105 couples, that marital satisfaction is significantly related to childbirth preparation. There are other aspects to the success or failure of social support for as Gottlieb (1992) points out an individual's satisfaction with perceived or actual support can influence its effectiveness. To be effective the source of social support has to be seen to be appropriate by the recipient. So the father must be considered by the mother to be functioning appropriately in the temporal and contextual climate of the labour room.

If the father is providing effective social support as perceived by his partner it is worth considering the benefits of such support. Cohen and Willis (1985) termed it 'a buffering effect' in that it buffers an individual's stressors in a stressful episode. Childbirth is an extremely stressful event during which the brain regulates the length of labour by the release of beta-endorphins (Jowitt 1993). During this time instinctive behaviour will take over in order to avoid pain. Stress hormones are also secreted

in situations of 'helplessness, hopelessness and lack of control' (Jowitt 1993) and the inability to manipulate the environment or the people within it causes stress hormone production to increase. It is likely that the buffering effect of the presence of the father will be beneficial to the woman. It may also according to Ganster & Bart (1988) dampen the adrenaline release leading to flight or fight syndrome, decrease emotional stress and encourage healthy behaviours. Odent (1984) considers that neurohormones have a distinct part to play in the relief of pain in labour and the activation of maternal behaviour in the hour after delivery. In his earlier work he advocated the presence of the father in the labour room (Odent 1984). However in his later work (Odent 1999) he concludes that the hour after delivery must be one in which the mother and baby are left alone and the presence of others (including the father) interferes with the neurohormonal response.

Gap Filling

One of the functions of the father in the labour room is to fill the gaps left by the staff. Hodnett 's (1989) carefully designed and executed Canadian study (n = 2235) found that hospitals recognized both that women needed psychological support and that nurses were either too busy or too unwilling to provide it. One of the key competencies of the British midwife is to be able to give care to meet the emotional needs of the mother and baby and the family (UKCC 1994 Rule 33). So in theory in the United Kingdom, this should not be a reason for encouraging fathers into the labour room. In practice it may be so because midwives may not be able to meet the emotional needs of the woman either due to their own inadequacies or inexperience or because of the pressure of work. Kirkham's.(1989) study of 113 women's labours found that midwives block women's information seeking behaviours and leave their needs unmet. Yet the midwife can give emotional support even when not always present, as demonstrated by Walker et al (1995) in their qualitative study (n = 32), by giving the woman the confidence that she,

the midwife, is immediately available as and when the woman needs her. Assurance of support gives the woman a feeling of being in control and this factor can provide a feeling of emotional well being. Ross and Mirowsky (1989) identified (n = 809) in a more general way that support and control can substitute for each other. So a person who is well supported does not gain anything more from being in control and vice versa. Niven (1985) pointed out from her quantitative study of 98 labouring women, that men do not always receive the support they need to help their partner during labour. This was sustained by the findings of Vehviläinen-Julkunen & Liukkonen (1998) in their study (n=137) of fathers' experiences of childbirth who found that one of the hardest things for men was to watch their partner in pain. Those men felt a need to be kept better informed about the labour and they also felt that the midwives should listen to fathers more than they did. This being so they should be in control in order to be emotionally equipped to give help to their partners. Walton (1993) did not find them to be in control of the situation because they had inadequate information about the duration of labour and socialization into the restricted use of space. It is possible that men themselves need both support and empowerment in order to fulfil their role in the labour ward whatever this might be. This is confirmed by a study (n = 83) of the effect of role clarity and empathy on support role performance and anxiety (Bramwell & Whall 1986) which considered that the degree of role clarity influences the adequacy of role performance. Essential to role clarity is the knowledge, of the goals of the role performance, of the behaviours and attitudes necessary for goal achievement and of role boundaries in relation to counter roles. This work suggests that perceived adequacy with the support role influences self esteem.

Mother's Advocate

Another function of the father is to act as an advocate for the mother (Barbour 1990). There are four key functions of advocacy (Durward &

Evans 1990) personal, professional, public and practical. Unless the father is a member of the legal, midwifery or medical professions it is likely that his actions are within the realm of personal and practical. In his role as personal advocate he will be involved in face to face contact with the health professionals and agencies on behalf of his partner. The philosophy of the maternity service is that it is dedicated to woman-centred care (DOH 1993) and in theory the woman normally acts as her own advocate. However there are times when for instance she is in very advanced labour that she may wish the father to take over the decision-making process on her behalf (Walton 1994). Or she may be under the effects of a general anaesthetic and a decision may need to be made. Barbour (1990) who noted that it meant for one couple that the man was 'on the woman's side' highlighted another aspect to the advocacy role. This implies that the care is not woman-centred and there is a view that the carers have a different agenda from the couple. Practical advocacy is a term usually related to pressure groups who provide for needs, which are not met by current statutory provision. In the case of the father this can mean ensuring that his partner is given access to patterns of care e.g. home confinement, which are hers by statute (House of Commons 1979).

Team Member

The final role of the father, that the literature considers, is probably the most contentious i.e. that of a subordinate well-behaved member of the team to help control the mother (Kitzinger 1991). The phrase contains within it the idea of a hierarchical power structure with the woman at the bottom, the husband slightly above her but below ascending ranks of caregivers. Writers such as Oakley (1984), Witz (1990, 1992) and Kirkham (1987) argue that such a structure exists. Whether the father is a member of the team or is in the same situation, as his partner is however not fully understood. The issue of being 'well-behaved' has many dimensions. If self-esteem is necessary to the fulfilment of a

supportive role it may be difficult to reconcile with being well behaved as defined by other and more powerful people. It certainly does not sit well with the idea of an equal relationship and empowerment, which may be necessary for advocacy.

At Risk Women

The existing literature on the presence of the father in childbirth tends to view the couples as a mutual and beneficial functioning pair. This view is a reflection of the societal factors, which conspire to maintain the concept of the family as an ideal. This model is evidently not so for all women and many have abusive partners (25% according to Neils and Brown 1988) who become more abusive in pregnancy (Bohn 1990). There are many factors which cause a man to abuse his partner and these include the need to have power and control over the woman, sexual frustration, stress, previous abuse as a child and low self esteem (Bohn 1990, Bewley & Gibbs 1991). Mercer and Ferketich (1990) found that on the whole those men who found it hard to be empathic, understanding and concerned about their wives were also ambivalent, resentful and fearful of fatherhood. This was a longitudinal study of 153 high-risk women, 75 male partners of high-risk women, 218 low risk women and 147 partners of low risk women. There was no suggestion that these men were abusive, but if the results are also applicable to abusive men then they may have particular difficulty in adapting to fatherhood and all that implies. Ferketich & Mercer (1995) from their study of 294 first time mothers, found that the type of pregnancy a woman experiences has an influence on long term family functioning. Men whose partner's had high-risk (of obstetrical complications) pregnancies were more likely to report family dysfunction at 8 months postpartum than were men who had low-risk partners. This contributed to family stress and disagreement on family matters, sexual life and family celebrations.

It could be important to the future of both the woman and her child not to antagonize a potentially abusive man by increasing his stress levels and so further reduce his feelings of inferiority, low esteem and frustration. It may also be important to have structures in place to identify and help these women who may need to labour and deliver without the partner present and may need the support of the midwife in facilitating such a move. There is an inherent difficulty for the midwife in identifying women with this problem. This is because the women, besides living in fear of the men are likely to have low self-esteem, suffer cognitive dissonance (Walker 1984) and feel ashamed of the situation. This being so they are likely to attempt to hide it from authority figures as much as possible.

At Risk Men

In pre industrial cultures expectant fathers have a set of learned socially sanctioned behaviours and restrictions which include particular dress, restriction on activities, avoidance of certain foods etc. (Summersgill 1993). This behaviour is termed *couvade* and can include mock labour. In current Western society there are no hard and fast rules for expectant fathers but Clinton (1986) found (n = 81) that men are still at risk from health problems associated with being an expectant father. These include headache, irritability, restlessness, and backache, colds, nervousness and weight gain. Men at particular risk from *couvade* symptoms are those with financial problems, pre-existing health problems men from ethnic minority backgrounds and those who have a high level of affective involvement in the pregnancy. Weaver (1982) found from a study of 100 men with a partner in the third trimester of pregnancy that expectant fathers demonstrate attachment behaviours towards the fetus during gestation in three main areas, differentiation of self, role taking and giving of self. This behaviour was positively associated with the strength of the marital relationship as perceived by

the father. The most significant behaviour was the demonstration of nurturing and although there was an increase in physical symptoms in men most involved affectively with the pregnancy these were not significant. Little has been researched into the couvade effect on Western men whilst the woman is in labour.

Invisible Men

It is quite common in anthropological literature to consider the invisibility of women (Ardener 1993) in the context of a male dominated society. It is also considered that the labour ward is such an institution with a rigid hierarchy of midwives and obstetricians (Oakley 1980, 1984, Kitzinger 1991). The woman is undergoing a rite of passage into motherhood and as such is being inducted into the role of passive, submissive initiate (Kitzinger 1991). She undergoes a period of socialization during which the rituals and ceremonials of the institution are brought to bear and during which she is expected to regress to a state of non-identity and compliance where her rights as an adult individual are abrogated (Kitzinger 1991). Less obvious is the fact that the men are undergoing a rite of passage into fatherhood in the context of a patriarchal society. It is more usual to consider patriarchy as gender based with men holding dominion over women but as Morgan (1992) points out the relationship between men and women is among other things a power relationship. Because patriarchy is primarily about power and pecking orders men can be object as well as subject in the relationship and in this case the father is object at the bottom alongside or perhaps slightly above his partner in the power stakes.

Whilst the rituals are not as dramatically obvious they are no less as effective. Men are socialized into their role by the use of time and space. In most labour wards the labour bed is positioned in such a way as to give a large amount of room for the midwives and obstetricians to work in. The father is allocated a chair at the side of the bed furthest away

from the 'work space' (Walton 1994). It is usually of the order of three feet by six feet in area. The father is very quickly made aware that it is not acceptable for him to leave this space. He may leave it to go home, to leave the labour ward area or to go to the lavatory but not for anything else. He is particularly discouraged from wandering down to the staff office or station (Walton 1994). Men are inhibited in their information seeking behaviour into the chronology of labour by various strategies (Kirkham 1988, Walton 1994). These are usually by the use of the vague reassuring but blocking type responses to direct questions about the course of the labour. The result is to disempower men and to make them passive and compliant.

The success of this strategy is shown by the actual lack of the awareness of the presence of the father in the labour records. It is highly unlikely that his presence will be recorded in the mother's notes unless he has made his presence felt in some way. Likewise in the labour ward birth register his presence may be ignored in many hospitals and the space for the names of people present at the birth will only record the presence of the professionals. It is highly unlikely that a man feels empowered in such a situation and enabled to take on the role of advocate. However the dominance in a power struggle is never absolute and alternative ways of knowing and understanding can develop (Morgan 1992).

Social support outcomes

In general the literature promotes the idea of the father as being a companion to his partner in labour to be a good thing. Having a balance between personal control and support in labour is the key factor in enabling women to maintain confidence and eliminate psychological distress. (Green et al 1990, and Walker et al 1995). Social support is thought by several writers (Lindsey 1992, Hodnett 1993, Price 1993, Keeling 1996) to have a protective function and to be related to positive health outcomes. So in general the presence of the father is seen as a

positive factor. There is a contrary view because as Keirse (1989) points out, as the number of support people have increased there has been an associated increase in the number of caesarean births and other interventions. This is reflected in a recent national study (Chamberlain et al 1993) into pain relief which found that although twice as many teenagers were unsupported in comparison with the rest of the study population (n =10,300 live births) they actually had a lower incidence of caesarean sections. There could be many reasons for this increase in intervention not least of which is the fact that a hospital confinement is managed from the obstetric viewpoint that no labour and birth is normal until it is over. This leads to early intervention which many have been found to “*cause positive harm*” (Tew 1995 page 374) followed by measures intended to counteract this harm which “*often only succeed in compounding it*” (op. cit.).

There is a fundamental problem in assessing the outcomes of labour which relates to the difference between ‘soft e.g. ‘depression’ and ‘hard’ e.g. mortality outcomes (Lomas et al 1987). They are also related to the different professional philosophies in that the medical professional has a leaning towards ‘cure’ whilst the midwifery profession is towards ‘care’. The hard outcomes are related to life threatening situations and so are easier to assess and to justify. This may be so even though they may not be the cause of the reduction in maternal and mortality rates (Tew 1995). The issues are complex in that they are related to professional and social factors. Soft outcomes are related to indicators of satisfaction with childbirth and are less easily and less often assessed. The main problem of measurement is that of understanding what it means (Bramadat 1993). There are differences between the emotions felt towards the evaluation of an event and those about the experience i.e. satisfaction is more than an emotional response

Conclusion

Women in labour used to be surrounded by a community of women and were helped by supportive rituals informed by female knowledge (Kitzinger 1992) Men were outside the main event but were also supported by their peers (Moore 1988). Now this has all changed and women are now distanced from their female relatives and in particular their own mothers with their own particular experiential and cultural knowledge. The only females they are likely be attended by are the midwives who will deliver care according to their own philosophy, educational background and models of care. These are increasingly likely to take a positivist, risk assessment and problem solving approach rather than a holistic, feminist and intuitive one. This is because midwives themselves are part of the structure of the labour ward and have only a limited autonomy over their practice. In addition the knowledge that is likely to be valued is that which falls within the paradigm of the natural sciences. This being so the woman at the centre of the care may be treated as a container (and a faulty one at that [Martin 1991]) of the fetus in a situation where the rituals are more likely to reinforce the alienation and subjection of the woman than to support her.

In Western society the cultural definition of woman is crucially dependent on the concept of 'mother' and this in its turn is connected to the universal subordination of women (Moore 1988). Is the presence of the father symbolic of further control over the mother or will the increasing presence of anti-sexist men (Christian 1994) herald a new way of empowering birthing women. The question is does the presence of the father affect the care the mother receives and if so how?

Chapter Two. Methodological and Ethical Considerations

Introduction

In this chapter I discuss the methodological and ethical issues that I considered and the methods that I used. I begin by considering the problems of identifying an answerable question and the effects that might have on the general social processes involved. I then discuss methodological considerations and later in the chapter I present my methodological approach. I show how my specific research questions and the methods I chose (semi structured interviewing, questionnaire and participant observation) developed from them. Most importantly I reflect on the problems that arose through the simultaneity of my roles as midwife, midwife lecturer, participant and observer as well as the familiar problem, in what is now sometimes referred to as auto-anthropology or anthropology at home, of making the familiarity of known settings, strange. (Hammersley & Atkinson 1991) I then discuss how post birth interviews, intended originally to be confined to fathers evolved into interviews with couples rather than fathers or for that matter, mothers alone. Finally I consider how the ethical issues posed by my choice of methodology were confronted and attempts were made to minimise any potential problems and how I always strove to ensure that no harm befell to any of the participants.

Following the review of the literature I devised the following general research question to consider the effect, if any, of the father's presence on the unfolding of events.

Does the presence of the father affect the care given to the mother, the decisions she makes and the outcomes of birth and if so how?

As I considered how to proceed it became obvious to me that the research question was not appropriate for several reasons. In order for me to answer this question satisfactorily I would have had to undertake a large randomised-controlled trial. It would have needed to have three trial arms with labouring women being randomly allocated to one, in which they were,

- Unaccompanied.
- Accompanied by their male partner.
- Accompanied by other companions.

This would have been almost impossible for me to achieve for as MacMillan (1995) found most men now want to be present during the labour and at the birth. I considered the potential difficulties of consenting and randomising women into such a trial to be too great. Also I would have had ethical difficulties both from a moral point of view and in practice with the various ethics committees concerned. However the main reason for not attempting to answer such a question was that it still would not give me an understanding of the meaning of the role as seen by the fathers. I then turned to the literature on methodologies to consider the best way to proceed. These I outline below.

Methodological Considerations

Qualitative Research

Qualitative research is that which produces findings arrived at by means other than those of statistical procedures or other means of quantification (Strauss and Corbin 1990). The data can be gathered by various means e.g. observation, interview, study of documents and photographs and it is then critically analysed, with social and theoretical sensitivity, and interpretations made. It uses theory to gain text, uses the text to move back to a theoretical position and then back again to more text. There are three broad approaches to the gathering and interpretation of the data that are discussed below.

Traditional Ethnography or Participant Observational Study

Ethnography is one of the most basic forms of social research, particularly in anthropology. The ethnographer acts as a participant observer and either overtly or covertly observes the social scene and the actors. He attempts to make 'sense' of it, just as any stranger in a foreign culture makes sense of what is happening, why it is happening and what meaning it has for the people involved. The anthropologist observes, records and takes part in the daily life of the people under study. An holistic approach is taken in that there is an attempt to understand attitudes and behaviour within their cultural setting.

There are two distinct stances taken for and against ethnography, both of which have their adherents. Positivists believe that the truth is out there and can be uncovered by reference to a 'covering law' and events can be explained by utilising the theoretical model which conforms to the law, formulating an hypothesis, examining variable relationships and deducing events to a generalizable set of findings. Value is given to directly tangible and observable phenomena. There should be no theoretical assumptions and the results should be arrived at in a neutral and objective manner. According to the positivists the issue is about deciding the suitability of the method, which should be modelled on the natural sciences and should be concerned with testing theories (Toulmin 1972). The argument against ethnography from a positivist viewpoint is that the data is of necessity contaminated by the participant observer and that it is not open to test. It is subjective and facts are collected in biased fashion, which are not open to replication. An opposite view to this is the stance of the naturalism school that argues that,

"Reality exists in the empirical world and not in the methods to study that world; it is to be discovered in the examination of that world.... Methods are mere instruments designed to identify and analyse the obdurate character of the empirical world, and as such their value exists only in their suitability in enabling this task to be done."

Blumer 1969

The prime aim in work based on this philosophy is that it remains true to the culture under study rather than adherence to methodological principles. It basically argues that the world cannot be understood in terms of cause and effect i.e. in terms of social activities people do not have set responses to stimuli. They interact either socially or symbolically, based on their understanding of the meaning of the stimuli to themselves at that particular time and in that particular context. This understanding is based on a wide range of philosophical, psychological, cultural and sociological assumptions. The description of the concrete, everyday experience of people within the culture, is the primary goal. (Denzin 1971). According to the naturalists ethnography is the perfect method for this type of study with the proviso that it stays at the level of cultural description because *"anything more is rejected as imposing the researcher's own arbitrary and simplistic categories on a complex reality"* (Hammersley and Atkinson 1991). The difficulty with this view is that like it or not the researcher's presence does have an effect, which can be great or small upon the social setting under study. According to Ball (1983) because of the influence of the presence of the researcher *"the conclusions he or she draws from the data are by no means necessarily valid for that setting at other times"*.

At first glance both these arguments would tend to make it look as if ethnography was not a valid tool to use i.e. it is either not scientifically objective enough or the presence of the researcher changes the situation under study anyway. Both these arguments are assuming that it is possible in some way to gain uncontaminated data in social settings. This is not the case and according to Hanson (1958) all data collection involves theoretical assumptions. Hammersley and Atkinson (1991) take this analysis further and suggest that resolutions to the problems so far identified lie in the use of ethnography with reflexivity. Their argument is that we are part of the world we study and this is an *"existential fact"* (page 15). This being so, ethnography can be utilized to give data on the

world as it is observed. Rather than make futile efforts to eliminate the presence of the researcher or to base it upon an epistemological foundation he or she will reflect upon the data in order to compare the possible meanings and identify the most plausible underlying patterns. Critical analysis and reflection upon the data enables the researcher to identify the emerging concepts, themes and patterns. Their presence can then be looked for in further observations. Ethnography enables one to develop and test theory and this is what makes it social and anthropological research rather than history or journalism. Because it is not tightly bound to one pre fieldwork design it can be flexible and enable the researcher to change direction and follow the evidence as required by the data. It therefore can facilitate greater understanding of the social system under study. For example if a case under study seems to be at odds with others then the researcher can reflect upon the evidence and test out his/her new ideas with further observations.

If one wishes to study the role of the father in the labour ward one of the obvious ways to do this is to go into the room and become a participant observer.

Unstructured Interviews (questions from the literature)

Going into the field as objectively as possible does not necessarily mean going without knowledge. Malinowski (1922) talked about foreshadowed issues. Most ethnographic studies are concerned with the development rather than the testing of theories and so do not choose the methodology appropriate to a particular theory. However there is a difference between preconceived ideas and preparedness.

“Foreshadowed problems are the main endowment of a scientific thinker, and these problems are first revealed by his theoretical studies”

(Malinowski 1922)

By rigorously searching and reviewing the literature prior to the fieldwork foreshadowed issues can be identified which can be used as guides in the conduct of unstructured interviews. The interviews are conducted

without recourse to a question schedule and so the interviewer can ask open questions loosely formulated around the issues but can follow up appropriately from the interviewee's lead. In this way although there may be several interviews conducted using the same foreshadowed issues the questions will not necessarily be the same.

Modern

The most typical example of modernism is the grounded theory research method first described by Glaser and Strauss (1967), which attempts to use a systematic set of procedures to develop an inductively derived theory about a phenomenon that is grounded in the data. *'It is a well thought out, explicitly formulated and systematic set of procedures for coding and testing hypotheses generated during the research process'* (Strauss and Corbin 1990). The written data from fieldwork observation interview transcripts or other documentation are scrutinised and studied. The aim of the study is to rigorously analyse the data and interpret what is found. A process of open, axial and selective coding is undertaken in order to develop an analytical framework. The work is examined in detail line by line and each discrete aspect is named as an identifying concept. The concepts are then grouped into categories and named by the researcher. The researcher then reflects upon the coding and categories and uses them in subsequent visits to the field in order to be as theoretically sensitive as possible. The process becomes more and more focussed with subcategories being related to the categories (axial coding). In this way the category or phenomenon is developed in terms of the conditions which give rise to it. The analysis can stop here at the level of themed analysis or it can be taken further to generate theory.

The creativity of the researcher is brought into play bringing the categories together and integrating them into a theory. One must conceptualise the story line and identify the core categories and then translate this into an analytical story. An analytical framework is then identified which enables the researcher to link the conditions and

consequences identified in the work. Part of the process is the writing of memos contingent upon the categories and concepts identified. They enable the researcher to record the way that (s)he has got to certain conclusions. In this way the researcher can determine which of the pathways and levels are relevant. This process continues until theoretical saturation of categories is achieved.

The proponents of this method argue that it is a rigorous, methodical and disciplined approach to qualitative data analysis. It is claimed that a key strength is that it generates theory from data that are constrained by a reality that is independent of the text (Seale 1999) and so supports claims with credible evidence. However it does have its critics e.g. Brown (1973) who questioned the usefulness of its application to some kinds of data. A more telling criticism is that of the post modernists e.g. Coffey et al (1996) and Coffey and Atkinson (1996) who consider that the heavy reliance on initial coding particularly when generated by computer software results in a standardized or even mechanized result. They suggest that a more thoughtful and reasoned discourse analysis should be attempted which tease out the subtleties and sense of particular words and fragments within the context. If this is not done then the meanings may be lost in decontextualised fragments linked together in artificial categories. They consider that grounded theorizing will result in a single interpretation of the data and the richness of multiple meanings will be ignored. Kelle (1997) considers that an approach similar to biblical hermeneutics may be a better approach whereby pieces of text are coded (or indexed) and cross-referenced to each other. This he would argue maintains the plurality of meanings rather than the artificial categorisation as described by Coffey and Atkinson. Denzin (1989) is one of the fiercest critics of grounded theory and declares it out of touch with present day qualitative researchers.

Grounded theory was developed to a scientific paradigm and as such has lost favour in the postmodern era. However it does not need to be used

so rigidly that it constrains rather than creates. Strauss and Corbin (1990) do lay heavy emphasis on the continual need for reflexivity and revision of ideas in the light of new evidence. It can be used to examine the text objectively and scientifically. This, being so, it can be a useful in developing a method for analyzing the fieldnotes and other data generated in the study of the father in the labour ward.

I decided not to use grounded theory as such but to use a modification. The method of analysis was broadly used in its outline as described in Strauss and Corbin (1990) but I changed the method of data collection in that I decided not to go into the field blind but would search the literature for foreshadowed issues. Also because of time constraints and the nature of the observational field I modified the purist approach in that I collected much of my data prior to analysis. I did, however revisit the field to check some issues that were thrown up by the reflection and conceptual analysis and I also felt free to abandon my strict observation schedule when it became apparent that there was more to see than I had thought of prior to entering the field.

Deduction

Knowledge gained by deductive reasoning is considered to be conclusive (Dancy 1992). When the process by which the knowledge is gained makes one's inferential judgement seem conclusive then it is deductive. This process is usually grounded in the physical sciences. Conclusive in this context is used (according to Dancy) in the special sense that it is impossible for the reasons or beliefs to be true and the inferences drawn from them to be untrue. In general the knowledge gained in qualitative analysis is reached by inductive rather than deductive reasoning but Strauss and Corbin (1990 page 148) maintain that it is possible when grounding theory to think deductively, *"hypothesize situations"* and return to the data to *"support, refute or modify that hypothesis"*. It is therefore quite reasonable to assume that some knowledge gained in this

study will have been arrived at through the use of deductive reasoning as part of the data examination and by the use of quantitative methods (see later).

Induction

Inductive reasoning gives rise to knowledge gained by a process that is considered sufficient to justify the conclusion. It can be considered in terms of probability. If it is considered very or more probable than other alternatives that the conclusion is justified then it is considered knowledge. However if the probability is not strong enough to warrant a belief in the issue under discussion it may be strong enough to warrant a willingness to believe that with further work there may be justification for accepting the belief. In this work my conclusions are inferred from the collected data and my interpretation will therefore be mainly be inductive.

Empiricism

Empirical thought states that what one claims to be true is based on the evidence of one's senses and can be verified and justified i.e. backed up by one's own and other's senses e.g. observations etc. An empirical (Dancy 1992) theory of meaning will be one that is dependent on data gathered by evidence from the senses rather than intuited. In this way one can say that the entire data gathering within the proposed research will be empirical. However issue could be taken on the point of verification. Unless there are more than one observers of the same phenomenon for example the role of the father in the labour ward the issue of verification is problematic. Unless all the statements made by the observer can be specified, and independently verified, then they are open to criticism by a sceptic. Some phenomenists (Ayers 1976) would argue that all the observer's data really tell is the state of the researcher's perceptions. The answer to this would lie in identifying all the research statements as dependent on the observation, but this would be a reductionist approach which would stand up to philosophical verification but would not lead to epistemological development. By using the data as

if it were empirically verifiable a holistic view can be gained i.e. one where the situation is looked at as a whole with symbolic interactions being interdependent. This is the approach that I use in gaining and handling the data.

Postmodernism

Postmodern thinking is in opposition to modernism that considers that there is a truth of how the world works and that we can discover that truth by empirical research and so can build a better society using this knowledge. There are according to Layton (1997) four strands to the writings of post modernists. They are that,

- (i) It is arrogant to think that the white European male can make an objective, comprehensive study of the world. (Bell 1993, Ganesh 1993).
- ii) It is an error to think that theories enable knowledge of the world as it is. (Foucault 1972, Derrida 1978)
- iii) If meanings are constructed from social interactions then there can be no collective consciousness as described by Durkheim (Bourdieu 1972)
- iv) All theories are political and must be judged by their effect on people's lives (Clifford and Marcus 1986)

Post modernism rejects the notion of one objective truth and emphasizes the plurality of viewpoints and the validity of signs, images and the spoken word. There is no single reality because everyone experiences reality from his or her own cultural, personal and political point of view and there can be a plurality of voices. This view can simultaneously have both conservative and subversive political tendencies (Gardener and Lewis 1996). It rejects blanket solutions for problems and so is not overtly political in the revolutionary sense. However by locating particular voices in a particular context and deconstructing what is said it can "*homogenise and exoticise*" (Gardener and Lewis 1996) and categorise groups of people such as 'women' or the 'poor'. Writings

(Foucault 1980) that emphasise the relationship between discourse and power show that to lump experiences or people together is politically suspect. Objectification of people is linked to political hierarchy.

Postmodern critiques centres very much on locating the researcher within the text, so for example, white feminists were criticized when they rejected a white man's view of the world in favour of the view of the 'universal sisterhood'. They were accused of appropriating black women's voices and making an assumption of shared experiences (Watson 1999). This constant emphasis on diversity and the claim that the local people are the only ones with the right to speak about their experiences can lead to fragmentation and the impossibility of talking about wide issues such as inequality or discrimination.

However, by rejecting deterministic approaches, the context or group under study can be focussed on in a more reflexive manner. The more eclectic approach, which is not bound to concepts and theories, allows for an understanding that the researcher cannot be truly objective and the status of his or her data is not uncontaminated. This can worry the researcher because there have been critiques of paradigms of writing anthropology (Clifford and Marcus 1986, Clifford 1988, Grimshaw & Hart 1994) that have led to a move away from ethnography. This has resulted in people taking more interest in analysis and deconstruction of text or moving towards the study of the powerful in their own societies rather than the weak or powerless.

A postmodern approach can take in the various methods of data acquisition such as ethnography, grounded theory, triangulation (Guba 1990), interviews and questionnaires and use them reflectively to illuminate the problems, issues or point of view of the group under study. The overarching condition is that the researcher uses sensitivity and as Geertz (1993 page 9) says the answer lies in using "*thick description*" and "*sorting out the structures of significance... and determining their social*

ground and import." The issue is not so much in the methods used to gain data as in their interpretation. The study, of the symbolic interactions or social discourse and the interpretation of such phenomena, gives rise to a framework for generalising within studies rather than generalising from studies (Geertz 1993). The aim is to interpret social interactions; i.e. language, decisions, behaviour, conflicts and hierarchies from a point of reality i.e. based on the observed and revealed information. It is not about intuitive or abstract interpretations.

Interviewing

There are four main types of interviewing situations, informal, unstructured, semi structured and structured (Russell Bernard 1988) that are loosely based on the amount of control the interviewer tries to exercise over the responses of the interviewees. The first two are rather freewheeling in that they impose no order on the situation in terms of time or control although the second does impose a formality in that both participants are aware that it is an interview situation. According to Russell Bernard the best type to use when one will not get a chance to interview the person again is the semi structured interview which is based on an interview guide with freedom to follow new leads as they emerge from the respondent. This is distinct from the structured interview where all informants are asked to respond to a fixed set of questions. (Self-administered questionnaires are structured interviews).

The interviews in this research apart from the questionnaires were all semi-structured and it was important to understand the criteria required to be met for a satisfactory experience. These are, reducing the power relationships (Oakley 1980, Kidder 1981), ensuring anonymity, non-direction, specificity, range, and, depth and personal context shown by the interviewer (Flick 1999). The issue of the interviewee being subordinate to the interviewer is always more obvious in the hospital situation but was reduced in this study somewhat, by holding the final

interviews in the couples' own homes. Anonymity can be assured as described in the consideration of ethical issues. Non direction is achieved by having flexibility in the use of the schedule and by using open questions and by creating a friendly atmosphere (Silverman 1993). Specificity i.e. bringing out the specific elements of the topic rather than remaining on general issues was sought by the use of probing, repeating, clarifying and reflecting questions and with the use of purposeful silence (Russell Bernard 1988). Likewise range i.e. the aim of covering the relevant aspects is similarly attempted by the use of such questions. Depth and personal context refers to the need by the interviewer to assess how the stimulus is experienced by the interviewee and to focus more on the other person's point of view by requesting further information (Flick 1999). There is an inherent problem when interviewing in that it is possible that the actors' perceptions may vary (Scollon & Wong Scollon (2001). This may result in bias which can only be overcome by ensuring a good questionnaire design and interviewer competence through practice and training. Categories or themes are generated either from the observational study and the subsequent reflections. These can be used to formulate a semi-structured questionnaire that is used as the basis of an interview. The questions are very open and so give the interviewee the chance to respond briefly or enlarge upon the area at will. The schedule forms a framework for the interviewer so that each of the interviewees is at liberty to interpret and clarify the issues as (s)he wishes. The interviewer can ask further questions to clarify and explore the topics in further depth but during the course of the interview all the questions devised from the data are asked.

Observation

Observation of behaviour can be divided into two main aspects, that of systematic observation and that of participant observation. Systematic observation *"involves the selection, recording and encoding of a set of natural behaviours usually but not necessarily in their natural setting for*

the purpose of uncovering meaningful relationships". (Kidder 1981 page 269). This type of observation entails building in measures to ensure consistency, reliability and validity. This is done by designing measures to overcome observer error, specifying the behaviour to be observed, inventing a measuring instrument and scoring system, and by time-point sampling. Participant observation on the other hand stresses the importance of observing people in their natural settings as a whole rather than one particular behaviour (Cheater 1991). Kidder (1981 page 280) defines participant observation as "a period of intense social interaction between researchers and subjects in the milieu of the latter, during which time data in the form of field notes, are unobtrusively and systematically collected." It is difficult to give hard and fast rules for the generation of data because the method is exploratory. However Bryman (1988) gives some advice in that he advocates trying to see through the eyes of the individual, paying attention to mundane detail, contextualising the data, having a flexible research design and avoiding the early use of theories and concepts which may fit poorly with the participants' perspectives.

Russell Bernard adds to this by noting that participant observation is not a method of data gathering but is a strategy that facilitates data collection in the field. By this he means that it reduces the problem of reactivity (people changing their behaviour for the researcher) and enables the researcher to formulate questions in the language of the field. The main skills required (Russell Bernard 1988, Silverman 1993) are the understanding of the language, the building of explicit awareness and good memory, achieving naivety (acting as a novice) and writing skills. As described elsewhere I as a midwife understand the language and have writing skills. I have had to work hard on the other three and in particular the attempt to achieve naivety.

Quantitative Analysis

Quantitative data are numerical data that have "*additive properties, equal intervals and usually a zero point*" (Oppenheim 1979). They have usually

(but not always) been gathered as part of a research project based on a positivist paradigm. Such research takes the view that there are inherent truths in the world (see above) and that the problems lie in the measurement of phenomena. It is an approach that relies on an attempt to make the researcher neutral and separate from the research and its findings. It is in general a reductionist approach (Sappsford and Jupp 1996) which attempts to explain the whole by measuring and correlating the behaviour (or parts of it) under study. The researcher obtains ordinal data which measure the relationships numerically and which are analysed quantitatively. This type of data can be statistically analysed in terms of means and standard deviations, analysis of variance, t-tests and f-tests etc. One of the most important aspects of the study for the researcher is the ability to demonstrate high quality work and its reliability and validity demonstrate this.

Reliability in Quantitative Analysis

Reliability is the term given to express whether the data is reproducible or not i.e. does it measure consistently what it sets out to measure? Obviously, errors can occur in any data collection method from matters within and without the researcher's control, for example there may be problems with the accuracy and suitability of the measuring tool and there may be user error. These can be overcome by using instruments that have been tested and re-tested. By giving the same questionnaire for example to the same set of respondents on different occasions over a length of time the reproducibility of the evidence can be determined. In order to ensure that the tool is as reliable as possible the items selected should not measure variables that may alter over short periods of time (Litwin 1995). Over a period of time the same respondents may become familiar with the questions and respond simply as they did the previous time. This is called the practice effect and can be reduced by asking the questions in a different order or worded in a different way.

Internal consistency is a measure employed in assessing scales and survey tools. It is an indicator of how well a group of items measure the same issue. It is usually time consuming to apply and requires the use of a computer programme to check the measures but can give rise to a scale that is very reliable. Statistically it is measured by Cronbach's coefficient alpha. To test for internal consistency one must have at least three yes/no items in the scale. The correlation coefficient should be as near to 0.90 as possible i.e. the measures have at least 81% in common or put another way they have four fifths in common. If the *"reliability drops below 0.80 this means that repeated administrations will cover less than 64%, and the error component is more than one third"* (Oppenheim 1992). Inter user reliability is where one observer collects the data whilst it is simultaneously collected by another person. This enables intra - observer error to be reduced and helps determine the inter-user reliability of the instrument.

Validity in Quantitative Analysis

Validity is the expression of quality in that it determines whether or not an instrument measures what it sets out to measure for example a broken thermometer will measure consistently so it is reliable however it will not measure the temperature accurately and so its readings lack validity. The attempt to measure validity is based on the identification of concepts and the reduction of these into more and more refined components that can then be measured. There are several types of validity when considering a questionnaire or survey tool. These are criterion, (concurrent and predictive) face, content, and construct validity. Validity can be expressed as correlation co-efficient.

Criterion validity is a measure of the accuracy of an instrument as a predictive tool. It is initially broken down into two components, concurrent and predictive validity. A test may measure somebody's response or ability accurately at the time of administration e.g. a student's ability to remember the current lesson. This is termed

concurrent validity and is measured against an existing standard. For example pain felt against an established pain tolerance survey instrument. The concurrent validity is expressed in terms of a co-efficient and once again the correlation co-efficient should be between 0.80 and 0.90. The problem with determining concurrent validity is the difficulty in obtaining an acceptable 'gold standard' to measure the items against. On many occasions the researchers wish to make predictions from their data and if the instrument is to be used in this way it must have predictive validity i.e. the ability of an instrument to forecast future events for example attainment in educational tests. Over a short time interval the test is similar to concurrent validity. However it involves correlating an initial test with another administered much later in time. It is expressed as a co-efficient between the two tests.

Face validity is the least scientific (Litwin 1995) and is the result of a superficial scan by an untrained person to see if the content seems reasonable. One could give the instrument to anybody to look at and if they were to agree that the questions looked 'okay' then this would be termed face validity. It does not have much credence in academic circles. Content validity is a subjective indicator of how appropriate the items are. Unlike face validity this is determined after a rigorous scrutiny with involvement of all parties involved in the administration or completion of the instrument i.e. professionals and recipients alike. It is not a scientific measure of the tool's accuracy but it does provide a good basis for establishing whether or not items or questions are well balanced (Oppenheim 1992)

The measure of how meaningful an instrument is, is termed construct validity and so is probably the most important in practical terms. It is however the most difficult to determine and measure. It shows how well the test confirms theoretical assumptions about abstract concepts such as intelligence. *"It is very often not described as a quantifiable statistic"* (Litwin 1995) but as how well the instrument performs over many years.

In summary it can be said that validity is a way of trying to express the trustworthiness of data obtained from a quantitative instrument and can be expressed as a co-efficient which is accepted (Robson 1993) as representing good validity at levels of over 0.70.

Validity and Reliability in Qualitative Analysis

Qualitative researchers at times have been uncomfortable with the accusations that their work is highly subjective and have tried to conform to the positivist method by attempts such as grounded theory approach (Glaser and Strauss 1967) that I have previously discussed, or triangulation (Denzin 1970). Triangulation is a method of validating observational data by cross checking against information gathered by other means. This conforms to the paradigm of convergent and divergent measures. Some ethnographers (LeCompte and Goetz 1982) pointed out that the immersion in the field by ethnographers over a long time, directly paralleled positivists' claims for measurement validity. Since the middle of the 1980s researchers have moved away from these attempts to simulate quantitative measures and have developed new criteria for assessing the quality of qualitative data. These are trustworthiness, credibility and dependability (Lincoln and Guba 1985, Flick 1999). At first there were attempts to link these very closely to the quantitative concepts for example credibility with internal validity and dependability but there is now more confidence in the ability of qualitative researchers to present data which is methodologically self critical and trustworthy although not unassailable.

Miles and Huberman (1994) take the view that

"there is a reasonable view of what happened in any situationand that we who render accounts of it can do so well or poorly, and should not consider our work to be unjudgable. In other words, shared standards are worth striving for" (page 277).

They attach a qualitative aspect to the positivist criteria and identify five issues. These are objectivity linked to confirmability, reliability and dependability with auditability, internal validity and credibility with authenticity, external validity and transferability with fittingness, and finally utilization/ and application with action orientation. Seale (1999) identifies that there are a bewildering variety of new concepts identified in the qualitative literature and he mentions at least eight types of validity associated with interpretative positions alone.

For the purposes of this research the view will be taken that the work can be judged and will use the five criteria as outlined by Miles and Huberman (1994).

Confirmability

The research process will be described in sufficient detail for the reader to have a complete picture and to be able to follow the process. The conclusions will be linked to exhibits of condensed and displayed data. Considerations will be made regarding the possibility of other conclusions. The data will be retained for re- analysis if necessary. Consideration will be given to the effect of personal assumptions, values and biases.

Auditability

The question here is whether or not things have been done with reasonable care. The research should be able to demonstrate findings that are meaningful in terms of clear questions congruent with the research design. The basic paradigms and constructs will be clearly specified and the data will be gained from the appropriate respondents. Data checks will be made wherever possible and appropriate.

Authenticity

Authenticity relates to validity in qualitative terms i.e. the 'truth factor' or credibility to the people under study and to the readers of the research findings. The research will be able to withstand examination in terms of richness of data and 'thick' description (Geertz 1993). The attempt to systematically link identified concepts will be demonstrated and areas of

uncertainty will be discovered and discussed. Triangulation methods will be used to produce conclusions that may or may not converge. Overall the understanding that emerges from the descriptions, the theoretical concepts that emerge, and the evaluative and interpretative meanings given to the work will demonstrate authenticity.

Fittingness

It is not usual to be able to generalize from qualitative data in the same way it can be done from large-scale quantitative studies. However it is possible to develop theory from the interpreted meanings. This is internal validity of a qualitative study (Maxwell 1992) and requires “careful interpretation not just adding up” (Miles and Huberman (1994). Questions that may be asked of the research to assess fittingness would be in regard to the assessment of the congruence of the findings in relation to appropriateness of the settings, and the generation of explicit, transferable theory with robust implications for future work. It is intended that this work will fit the fittingness criterion.

Action Orientation

This criterion refers to the response to the research of decision-makers and is crucial in assessing the impact of action research. Questions that address action orientation revolve around issues of whether or not the findings lead to specific actions or what level of usable knowledge is offered. This may or may not be applicable to this work. However it is envisaged that other questions relating to the subsequent empowerment of the participants, or whether or not there are value-based or ethical concerns raised by the findings may be answered in this research.

Methods

On consideration of the literature I decided to use an approach common in so-called anthropology (Layton 1997) that combine both qualitative and quantitative aspects in a mixed methodology. I therefore decided to reframe the main aim of the research in more general terms as,

An ethnographic study of the role of the father in the labour room of a modern British hospital.

I decided to use this mainly ethnographic approach because it asserts the usefulness of more than one source of data and method of data collection in order to build up as holistic a view of the happenings as possible. Having decided to do this I developed very specific subsidiary aims in mind to use as a very loose framework for the study. (See Text Box 2.1)

In order to gain such a view I set out to obtain data from more than one source with the intention of triangulating it as far as possible (Denzin 1992). I used such triangulation to combine both quantitative and qualitative approaches but with the major emphasis on the qualitative. In the past there have been paradigm disagreements

(Tashakkori and Teddlie 1998, Lincoln and Guba 1985, Cronbach 1982). However it is now fairly recognised (Howe 1988,

Guba and Lincoln 1994)), that there can be compatibility between paradigms and it is now accepted as a new paradigm.

TEXT BOX 2.1 SUBSIDIARY AIMS

- *Examine the fathers', the mothers' and the professionals' expectations of the role of fathers in the delivery room.*
- *Observe the interactions between the fathers, the mothers and the Healthcare professionals in the delivery suite.*
- *Identify the role performance exhibited by fathers in the labour ward e.g. coach, passive observer or assistant to the midwife*
- *Identify the support needed by labouring women from both the professionals and the father in order to have control over their labours.*
- *Identify the needs of fathers whose partners are giving birth.*

I used such a paradigm with an eclectic mixture of methods e.g. participant observation, interview and questionnaires that are mixed qualitatively and quantitatively in order to achieve the sub aims. These in turn lend themselves to computer-aided data analysis (modernism), symbolic interaction analysis (postmodern), statistical analysis (positivist) and discourse analysis (postmodern). By using such an eclectic approach I hope to be able to demonstrate a richness and deepness of findings where I am firmly placed within the research, without abandoning an objective approach and can therefore retain, as far as possible, a lack of bias in relation to the results. The voices of the participants are clearly heard and include mine as a participant observer. I have attempted to understand and to interpret what the presence of the father in the labour room means to all those involved.

Sampling

As I have said the literature is concerned mainly with description, if not always analysis, of functions that might be fulfilled by the father. I wanted to know, however, what the parents and the professionals thought were the key reasons for his being in the labour room. So I devised a short, loosely structured semi-structured questionnaire (appendix five) and used it (modified for the intended subject and tense) as the basis of a series of interviews with pregnant women, expectant fathers, doctors and midwives. After obtaining ethical approval I gained access to the men and women, the health professionals and mothers and fathers through the maternity unit managers. I approached the last mentioned and they recruited people for me. People who agreed were given full information orally, given an information leaflet and then interviewed either in their own home, the private rooms of the hospital or in my office at the University, whichever was most convenient for them. The interviews were tape recorded and transcribed. The sample consisted of three midwives of mixed age and experience, three doctors (one man and two women) three pregnant women, and three newly delivered mothers and fathers. I interviewed a

larger total of five expectant fathers by mistake because I believed erroneously that the tapes of two men had been wiped out and so I recruited two more.

Initially, I manually analysed the transcripts in order to generate concepts. Later I used the Win Max Pro computer package to expand this analysis. The initial concepts were then used as the basis for a quantitative questionnaire (appendix six).

Quantitative Questionnaire

The quantitative questionnaire was administered to 100 each of pregnant women, expectant fathers, new mothers and new fathers. It was given to all (n=20) the doctors in the maternity unit and 50 midwives. The participants, apart from the doctors and midwives, were selected opportunistically. The questionnaire was administered to twenty-five hospitalized pregnant women and their partners, twenty-five pregnant women and their partners attending clinics, and ten community midwives took five of each to distribute in their outlying clinics and postnatal visits. This was repeated for newly delivered women. To select the midwives I firstly obtained a list of the midwives in employment from the Head of Midwifery Service. Then after excluding those on annual leave or absent through long term sickness or maternity leave I gave them each a number and then selected fifty using a table of random numbers. I sent the questionnaire to them through the internal post. The respondents returned the questionnaires to me in a free post self-addressed envelope.

Field work

The observational phase took place in over a period of eight months from October 1997 until May 1998. I observed the labour and delivery of fifteen women. I recruited the couples on the labour ward itself. Initially I approached the shift leader who looked at the white board on the wall (see chapter three) at the midwives' station to see if there were any suitable couples on site. I considered any woman to be suitable if she was in early labour, had her male partner with her and did not have an

intrauterine death or abnormal fetus. The shift leader then approached the midwife caring for the woman and asked her if she would be happy for me to attend. If she agreed then she would approach the couple in the first instance so that, if that was their wish, they could agree or refuse without having to see me. I then entered the labour room and explained who I was and what my research was about, gave them an explanatory leaflet, and gained their written consent.

After two or three labours I decided not to use the observation sheet alone as it was too constraining and I felt that I might be in danger of not recording something pertinent. So I decided to observe closely, to make contemporaneous field notes and then to analyse them to identify what I was seeing.

Merging Roles

In this situation I was a midwife, a midwife lecturer, a participant and a researcher. I was mindful of the ethical issues discussed in Chapter four during my time as participant observer but I did not on the whole find it too problematic. I decided from the start that I was privileged to be in the labour room precisely because I was a midwife and so I made no secret of this fact from the couples. I did, however, hope very much that I would not have to act as a midwife in any way. However 'just in case' I familiarised myself with the alarm bells, the contents of the cupboards and the whereabouts of the resuscitation equipment. Initially one or two of the midwives, in particular a recent graduate, and another, a very experienced midwife, tried to draw me into looking at case notes and discussing the care. When I made it clear that I was not there in the capacity of a lecturer they relaxed and eventually ignored me. I tried to be participative in that I talked and discussed matters with the couples and laughed and held their baby after birth. I tried, in this and other ways, to avoid making them feel like specimens under observation.

The Familiar as Strange

One of the problems of doing ethnographic research in one's own field and place of work, is the difficulty in being able to 'see' what is going on. Instead of artefacts and events being confusing, peculiar and even bizarre one takes them for granted because one has already been exposed to them over a long period of time. I was no exception to this tendency and so tried very hard to look reflexively and to overcome my prior knowledge, assumptions and prejudices. This I did by actively looking and listening. I asked myself questions about which I thought I knew the answer for example "why is the midwife going to that cupboard now? What is she doing? I also dressed very quietly in dark colours, stood on the father's side of the room and did not follow my 'midwife' impulses to tidy the room or help with the procedures!

Post Birth Interviews

During and following the observations of the labours and births I identified concepts such as 'distancing' which I incorporated into a semi structured questionnaire (appendix eight). I then used this as the basis of interviews with the couples. Originally I had asked could I have an interview with the fathers following the birth but with one exception I was faced with the couple on arrival and so included the woman in the interview. These took place in their own homes between six weeks and six months after the baby was born. I transcribed the interviews and analysed the transcripts with the aid of the Win Max Pro computer package.

Ethical and Philosophical Stances

There are two main philosophical schools of thought that impact on health care and its related research. They are deontology and utilitarianism. Deontology (from the Greek word deon meaning duty) is concerned with the obligations or duties of a person as being derived from reason or certain specific rules of conduct rather than from the analysis of the possible consequences for example the maximisation of

some good. The main influence in this field has been Immanuel Kant (1734-1804) who considered that some principles are moral in themselves and that human beings have “the capacity to recognize this” (Seedhouse 1998). Kant’s imperative is that truly ethical behaviour is originated by a pure motive based on duty. This contrasts with the stance taken by Utilitarianists. Utilitarianism (or consequentialism) is based on the belief that a person should act in order to reduce the greatest amount of good over bad. The problem with this doctrine is the definition and measurement of good over bad and the determination of cost to benefit which is open to possible abuse if one party has more power or influence than another in society.

In general the practice of doctors and midwives is based on deontology and the basic duty is outlined in either the Hippocratic Oath or the Midwives Rules and Codes of Practice and Conduct (U.K.C.C. 1998). Beauchamp and Childress (1979) published a four-principle approach to medical ethics. These are beneficence, non-maleficence, justice and respect for autonomy. Although these can be criticized (Seedhouse 1994) as having no underpinning philosophical structure they have been taken on board wholeheartedly by health professionals and used as guides to moral behaviour in clinical practice and research.

U.K.C.C. Rules, Code of Practice and Code of Conduct

As previously stated midwifery is based on deontology and also the four-principle approach. In this case I am a midwife and the health professionals who are the gatekeepers perceive me as such. I as the researcher have a duty of care as outlined in the U.K.C.C. Code of Practice and the Midwives Rules that override any neutrality as a researcher. In reality this means that the research is designed to meet Kant’s advice to treat the person as an end rather than a means. The beneficence criterion is met by ensuring good outcomes for the research participants whilst avoiding or minimising unnecessary risk, harm or

wrong. The obligation is to provide benefits, and to balance benefits against risks.

Non-maleficence or the obligation to avoid causing harm is extremely important and so from the outset the participants were told that I am a midwife but that I would not take part in direct care. However I was mindful that in an emergency situation or if I was to observe malpractice then I would initiate the action appropriate as an experienced midwife.

Respect for autonomy obliges one to pay due regard to the decision-making capacities of autonomous persons. I fulfilled this duty by building safeguards into the research design to ensure that people were treated with courtesy and respect, given information and the choice to participate or leave the study as they so wished.

Ethics Committees

In order to follow the principle of justice the study had to demonstrate fairness and ensure reasonable, non-exploitative and carefully considered procedures and their fair administration. In order to ensure this the research design and the information leaflets were presented to and subsequently approved by the University and Trust Ethics Committees. (see appendix one).

Informed Consent into the Study

Leaflets (appendix three) were designed that aimed to give people as much information about the study and their rights as participants as possible. In particular they were given my contact address and telephone number. They also stressed that the people had the right to leave the study at any time if they so wished.

Timing of Consent in Labour

Labouring women were considered to be a vulnerable group by the Ethics Committees so it was thought that the best approach would be to give them information prior to labour. This would enable them to discuss with the father of the baby the possibility and implications of taking part in the research. They would also be able to reach a decision before they came into hospital. With this in mind information leaflets were placed in the

case notes of all the women who were booked to have their baby during the planned period of observation. I approached them in labour only when it was obvious that they were not having a contraction and were not in pain.

Ability to read and understand English

I attended the labour ward on an ad hoc basis and so the recruitment into the observational aspect of the study was opportunistic. In order to ensure that the couple understood the consenting procedure and also so that I could understand the interactions, I decided that only women and men who could speak, read and understand English would be admitted to the research. The midwife responsible for attending the woman initially assessed this ability on my behalf.

Vulnerable Women

Pregnant girls under sixteen and women carrying a fetus with a known abnormality were excluded from the study. Also women who were known to have a dead fetus in labour were not approached.

Privacy and Confidentiality

According to Seiber (1992) privacy refers to the person and *“to their interest in controlling the access of others to themselves”*. Confidentiality is a sub set or extension of privacy and refers to records and information about the person and about the way that the data is handled in order to maintain the individual's privacy. The research process is a contract between the individual and the researcher and rests on the basis of informed consent. In this study I gave the participants as much information as possible both verbally and in written form. They were assured that no information would be gained from case notes without their written consent (appendix three). Also at any time during the fieldwork they could withdraw from the study, which in effect would mean that I would be asked to leave the room. When the woman was in labour I would respect the couple's privacy by only entering the room when they were more or less in the 'public' aspect of the labour i.e. when

the midwife was present. I usually entered with the midwife and left either with her or shortly after. At other times they would be left alone, as was the normal practice in this particular hospital. The assumption was that the couple needed and wanted privacy. It is probably true to say that this was a pragmatic decision based on staffing levels and the number of other women in labour at the time. Ethically the couples as autonomous beings should have been asked and given the choice of having (or not) an attendant to stay constantly with them.

All observational data was obtained by overt means.

Interview questions were devised to be as sensitive as possible because privacy issues can be very subtle. Relatively innocuous questions, such as, asking the father was he present at the previous birth, can cause difficulties. These dilemmas were addressed by ensuring that the couples understood the confidentiality agreement and also because I am a midwife with over twenty five years experience of talking to pregnant women and their partners.

Anonymity

The couples' privacy was assured by ensuring anonymity in the data. Full names and other identifying markers were not used. The addresses and contact telephone numbers were kept separately from the full names at my home. Raw fieldwork data was only available to my supervisors and only as transcripts. All tapes and identification will be destroyed after this thesis is accepted.

Needs of, and Respect for the Gatekeepers

In a research study there are third parties that have the power to allow me access to the study participants. In this study these were mainly the midwives and the obstetricians of the Trust and the academics on the University Ethics committee. The initial gatekeepers were the members of the University and the Trust Ethics committees. They acted as subject advocates in the scrutiny of the design and when their concerns were satisfied they gave permission to access the next group of gatekeepers.

These were the midwives of the Trust and the people who were involved in giving direct care to the women. They had the power to negotiate with the couple and gain permission for me to approach the couples either in the early part of the work or later in the crucial observational period. It was important that I realized that they first and foremost saw me as a midwifery lecturer because this presented two problems that had to be overcome. First, they had to be reassured that I was not there to observe their practice, and second, I was not there to help or give advice. I addressed these two issues each time I approached an individual midwife at the start of an observation. The protocol stated that the women and their partners were to be approached by the midwife and asked would they consent to discuss the study with me. This was to give the couple the opportunity to refuse if they so wished without having to directly confront me. However it left the gatekeeping midwife the opportunity to influence the couple in whatever way she so desired. I pressed the point that the couple was not to be coerced to enter the study. I also secretly hoped that they would not be influenced against the research. This might be a possibility if the midwife did not feel comfortable with my presence. In order to avoid this I did my best to be as unobtrusive and non-threatening to the midwives as possible.

Conclusion

In this chapter I drew attention to how difficult, if not impossible, it would be to show the effect of the father's presence on the outcomes of labour and so described the rationale for an ethnographic approach. I have given overview of the methodological and ethical issues and the choices I had to make in order to select the methods that I used. I discussed some of my considerations about the potential difficulties of having a mixture of roles and how I resolved my own internal conflict and tried to minimise potential problems and act in the best interests of the women at all times.

I did not discuss the theoretical framework in detail because I hope to show how theory is developed inductively from the data rather than deductively. No specific hypothesis could be generated from the literature although I devised subsidiary aims and foreshadowed the issues, which I used to semistucture, the initial interviews. However by using a systematic approach to analyse these interviews, (which I describe later) the concepts that I generated to act as working signposts to revisit the data or to think deductively. Unsurprisingly the anthropological literature on rites of passage initiated by Van Gennep (1909) and developed by Victor Turner (1990) and, especially in this context, by Robbie Davies Floyd (1992) proved to be a useful starting point.

Chapter Three. The Context

Introduction

In this chapter I set the research in context. I introduce the hospital and its setting as an outsider may see it. I explain the difference between the labour ward and the labour room and track the path to the labour ward along the way that a couple goes to reach the labour room. I consider such difficulties and obstacles as the problem of getting in at all and the way that midwives act, literally as gatekeepers. I describe the labour room and its contents and explore the concept of privacy as it relates to the couple. I discuss how the midwives see it, and how the room itself acts as an obstruction to privacy. I show the way in which the father and mother to be, separated by the positioning of the furniture and the level of the labour bed, are both deprived of power over what may appear to them as a hostile environment. Finally I mention in passing the additional ways in which the father's power is reduced, not least by the rituals surrounding his access and occasional expulsion from the scene. I end the chapter with a summary discursive account of the birth process as it is enacted in a hospital.

The Labour Ward - A bounded Space

External

I conducted my research in a large ultra modern inner city hospital that I have named, for thesis purposes, after Diana, Princess of Wales who did in fact declare the building open. It is sited in an area of mixed urban dereliction and regeneration. The population in the immediate surrounding area is made up on the whole of working class or unemployed people with pockets drawn from ethnic minorities. The district has sizeable Somali and Afro-Caribbean populations, for example, and it lies close to the city's China town. It is easily accessible from the

city centre by bus, taxi, or for the fit and able, by foot. The Princess Diana serves the major part of the city, which takes in a wide-ranging section of the public.

It is a large pale brick building topped with an imposing bright blue roof and surrounded by a large enclosed area, which is almost totally taken up with shrub-surrounded car parks. My first field visit took place on a wet, dark day in October, and sitting in my car I felt apprehensive (See Text Box 5.1). I had dealt mainly with the senior staff of the hospital in my official capacity but I had never worked there and although I knew many of the midwives by sight, I did not even always know their names. There were others I did not know at all.

This feeling of apprehension was on the one hand very real and on the other quite perplexing. Why

was I, an experienced midwife feeling like this and if this was happening in an environment which on the whole I was familiar with wouldn't it be so much worse for the women in labour and their companions. At least I had been there before, understood the midwifery profession and was not in pain.

Entrances and Exits

I entered the hospital proper by the main door that was fronted by a little road traffic island. Opposite was a queue of taxis waiting for business.

TEXT BOX 3.1

EXTRACT FROM THE FIELD

NOTES - Arriving for the first time.

- *I feel rather apprehensive.*
- *I know where to go but there are two doors.*
- *Would I know which ones to use if I was arriving for the first time?*
- *I know some midwives but not others.*
- *I wonder if I will be made to feel welcome?*
- *There have been blank stares on some occasions in the past. I hope there are some friendly faces today.*
- *It must feel like this for the men and women as they arrive. Or even worse!*

Through the double doors was a large open space, part of which was designated as an open plan sitting room. Directly opposite the doors was a reception desk. This was very busy with people passing in front of it going towards the dining room (signposted to the right) as well as towards the ward areas to the left. Although I knew the way I waited my turn and asked the receptionist. She was pleasant and I was directed down to the left and told to find my way by means of picture signs. The three floors were symbolically designated as earth, water and air. The ground floor was earth and the first floor was water. The labour ward is sited on the first floor and the sign for the labour ward is a dolphin. Following the dolphin was relatively easy, down a long corridor, turn to the right, down another and up in the lift. Directly opposite was the labour ward. A locked double door confronted me and on pressing the doorbell a disembodied voice over the intercom asked me (in a tone that belied the words) if she could help me. I identified myself, a green light came on over the door and I was told to come in. I entered the anteroom. This is a large L-shaped passageway. (See diagram 3.1). The short arm of the L has chairs lined up against the wall. To the right of the long arm is a treatment room and to the left a visitors waiting room containing a Coca-Cola machine and a toilet. Directly opposite is another locked door. I went forward to ring the bell but before I could do so, once again a green light came on over the door and the voice told me to come in.

Internal

The first impression of the labour ward proper is that of a long corridor. I walked down the corridor towards the midwives at the end. They were clustered around a large white board on the wall. To my right and left were two alcoves, each of which had two doors at the end. These were the entrances to the labour rooms.

The labour ward is actually shaped in a modified, Bentham-type, panopticon cross design (Foucault 1991). At the end of the first arm are a small kitchen and the hub of the place, the midwives' station. This is a

reception type area enclosed by a desk structure and entered at one point only. The midwives either sat within the closed area or stood before the whiteboard. The whiteboard contained information about the women in labour that day. Squares designated the labour rooms with each being identified with the woman's name and abbreviations for her progress in labour and the first name of the midwife and student midwife caring for her. To the right of the midwives' station lies another corridor containing, on the right, the staff toilet and coffee room and three more labour rooms. On the left are a stock cupboard, small teaching room, the manager's office, two labour rooms and a water birth room. To the left of the midwives' station is a corridor housing three more labour rooms (larger and used for more complicated deliveries) and stock and equipment rooms to its right. The top part of the cross is a corridor leading to doors that opens onto the operating department. Walking down this corridor is an unnerving experience for the new comer. I felt very exposed (as no doubt did the couples who entered) and I recorded that it felt *"like and endurance test"* _{m3}. To gain entrance to any labour room except numbers eight to ten and fourteen to seventeen on the first long corridor, one has to go into the centre of the cross and to pass the midwives station.

Gatekeepers

The midwives have a television monitor over the station by means of which they can view the outer and inner doors and the visitor's room. They control the entrance by means of a switch at the midwives station. Going out through the door is also not easy. On the wall, some distance from the door, there is a not very obvious buzzer which one has to press to open the door.

The labour rooms - Size Décor and Layout.

The labour rooms are small (approximately thirteen feet square and each one is very similarly furnished (see diagram 3.2). The following description (observation no.1) is typical. Some of the rooms look out onto

the square as described and others on the other side of the corridor view the hospital grounds.

Observation No.1

A small labour room the contents of which were a curtain around the door, delivery bed, armchair, large bins, trolley, television set affixed to the wall. Directly opposite the door was the window that overlooked a courtyard and opposite a main hospital corridor so the curtains were kept closed most of the time. To the right of the door was a small wash basin and then another door leading to a small vestibule off which was a shower and separate toilet. Opposite the door to the left and adjacent to the window was a small pine wardrobe which contained the sterile packs. The bed was to the left of the room and was placed parallel to the window and wall doors. The armchair for the partner was placed between the bed and the door to the vestibule. Behind it were a drip stand and a bed table containing jugs of water and orange juice. A rocking chair was in the right-hand far corner between the bed and the window. It was standing in front of a cardiography (fetal heart rate) monitor. obs1

Privacy

The couple is generally left alone for 15- 30 minutes at a time in labour and so have a certain amount of privacy, which for some couples seemed to be enough (See table 2)

Post Delivery interview no.1

R I mean were you able to have as much privacy as you needed?

J Erm, in, what through the, after he was born or during it?

R During the, you know, in the labour, in the labour ward?

J Erm, yeah because, obviously with the private rooms and that you were er, obviously in the erm, in the private rooms you know to yourself, what you've got, I mean that, I mean, the, I mean you, you realize that people are coming in all the time and checking on s so obviously it's like, not sort of totally private, because other people arebut er, but yeah I mean, no if you wanted to talk to S ? nothing like that.

Field Note Post Observation interview no.2

R Do you think you had as much privacy as you needed?

I Yeah, oh I yeah. Cos of, when she said like we were left alone, I mean they'd pop in and she was asleep, and I was just watching the telly and reading the paper, and yeah, it was very private, I thought it was excellent, the way they run it there. Like the room with the television on, cos I thought after she'd had the baby we're going to be moved now, and she said no she'll be having the baby here, and it just relaxed her, it was like....

It is unclear whether or not the leaving of the couple alone was really to give them privacy or was a pragmatic decision based on the staffing levels and customs of the labour ward. As described in the previous chapter there is a body of literature that advocates that women in labour are attended throughout on a 'one to one' basis. However it was obvious to me that this was not always possible as the midwives were often attending to more than one woman in labour at a time. Moreover it is possible that the midwives themselves thought that they were ensuring privacy for the couples. This was evident in remarks such as *"I think you two have had enough of my chat for now. I'm just going next door but if you want anything give me a buzz"*^{po5}. This was obviously a directive and phrased in such a way as to be relatively unchallengeable. I did not hear any couples asked would they like to be left alone or have the midwife stay with them.

The siting of the labour bed is such that the woman's lower body is the first thing that is seen on entering the room. A midwife criticized this design as being *"thoughtless and stupidand lets the woman and all her 'bits' be on show to the world and his wife."*^{mw6}. At the midwives' insistence a curtain has been put around the entrance on the inner side

of each door and people are encouraged to identify themselves after knocking and opening the door, before entering the room proper. So the woman and her partner's privacy are protected from others by the midwife designated to care for her but it is not under their own control. They are not shielded from the designated midwife or from the doctor.

Control over the environment

The couple has little or no control over the environment of the labour room. They are in it but have little or no power over it. There are no locks on the labour room doors and so the couple cannot be completely private. The woman lies or sits on the bed the height of which can be adjusted by the midwife. Alternatively she sits in the rocking chair. She, like the man is powerless, to adjust the bed in any way and so is the man. I never saw a man shown how to adjust it and the implicit message appeared to be that the midwife controlled the environment. She shut or opened the curtains and she turned the television on or off. All the women either sat on the rocking chair or on the bed. When they moved it was to the toilet or back again and they were helped in this either by the midwife or by their partner or by both depending on the stage of the labour. The men could and did move their chairs. However they were allotted a certain portion of the labour ward. This was made clear by the use of the furnishings and the initial directive to sit down (see diagram of labour room). The labour room can be symbolically divided into the midwife's working space and the 'other's' space. The midwives space is the larger and is always on the woman's right hand side, so that as the midwife faces the woman her back is to the bottom of the bed and her right hand is alongside the woman's right hand side. This means that the man is on the left-hand side of his wife and is in a relatively awkward position. If he sits with his back to the wall he is sitting parallel to his partner and can only hold her left hand with his right hand. However this is not practical in that it is a difficult position for eye contact. Also he has to sit further forward because there is usually a drip stand on this

side between him and the wall. If a drip is 'in situ' it is invariably inserted into the woman's left hand and so they cannot hold hands properly. In this case the man often holds her lower arm.

If he sits at right angles to his partner he can have eye contact if they both turn their head to each other. He can hold her left hand or arm with both his hands. The third position he can assume is that of turning his chair so that it faces the wall and he can be completely facing his partner with his left hand lying along side her left hand. The advantage of this is that he can have eye contact more easily but still has the disadvantage of only enabling arm contact if she has a drip 'in situ'. It is also quite awkward in that his chair is quite large and in this position takes up more room. If he is not careful the back of the chair will overlap the end of the labour bed and will then be in midwife's space. If the room has the bed to the right-hand side he will be intruding into the area through which the midwife and the doctor will walk to their side of the bed. He will thus be overtly intruding. If it is a bed to the left of the entrance door his intrusion will be less noticeable.

The wall facing position will also restrict his movement. In order to leave the chair he has to stand up, walk sideways to his right and then turn round and out to his right. Not surprisingly, rarely was the chair (if ever) moved into this position. The right angle position was favoured in early labour and the back to the wall one in the later part of the labour.

When the woman gets on the bed the midwife raises it so that the woman is at a suitable height for the midwife to attend to her without bending too much. In theory the bed should be lowered after the midwife has carried out her observations but in practice I did not see this happen. The effect of this is that the man is left sitting at a much lower level than that of his partner. I felt that this looks uneasy.

Exiting

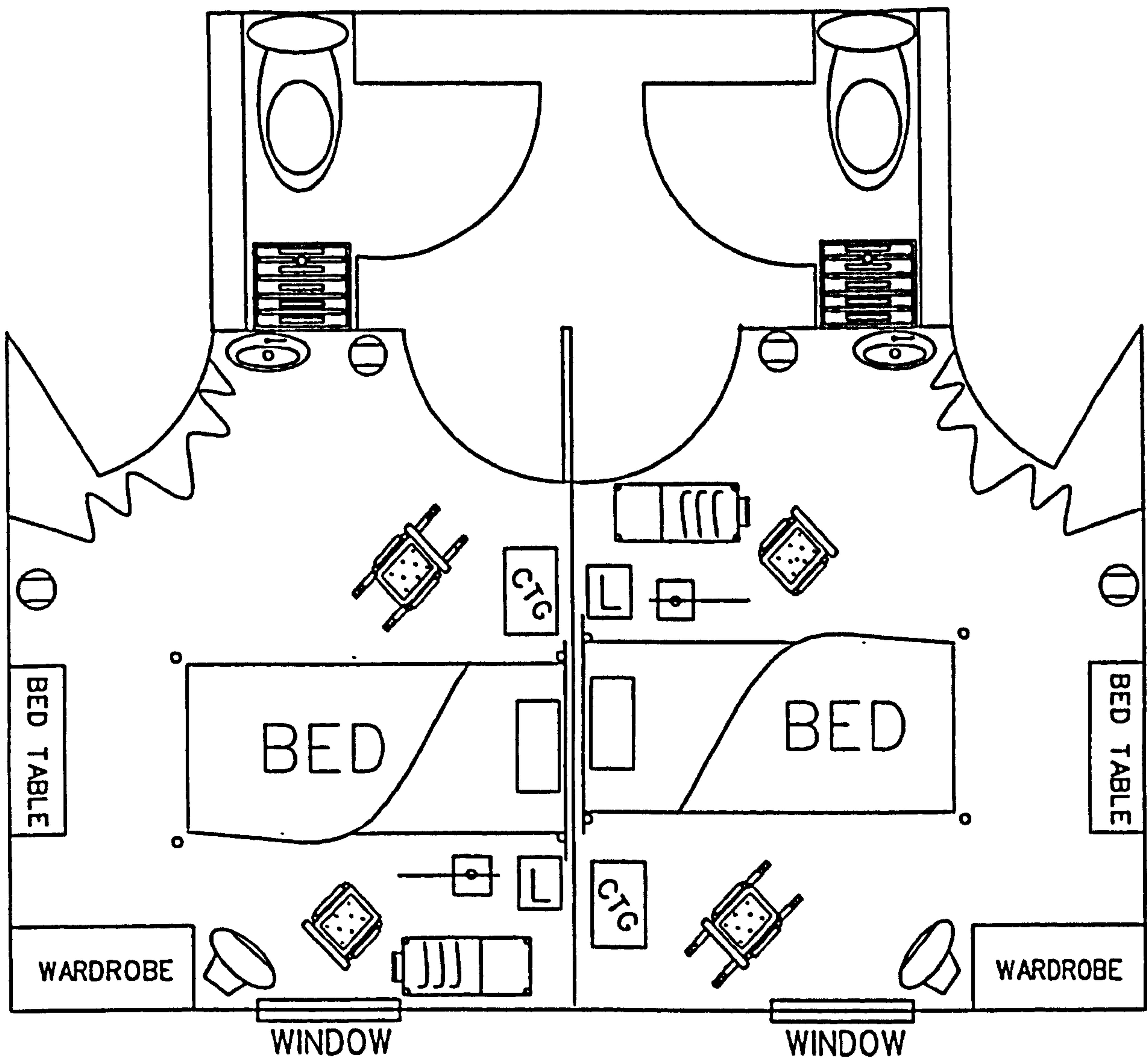
The men could enter and leave the rooms and the labour ward at will and they did so. However the entrances and exits on the whole looked

uncomfortable. To exit the room the man had to leave his space. If he was in a room with a bed to the right it was easier to leave because unlike the room with the left-hand bed he did not need to move through the midwife's space. He merely had to slip through the curtain and leave the labour ward proper. This was somewhat of an ordeal because he then had to walk the length of the corridor and pass the midwives' station. When the men were moving the midwives ignored them but if they stopped at all they were asked did they need help. This acted as a deterrent to stopping and also appeared to be a measure to maintain confidentiality by the midwives in that it prevented the men from reading the information on the whiteboard. However it would be unlikely that they would be able to glean much from this information if they did read it because it was written in abbreviated jargon such as '*Smith g2p1 5cm. SRM. peth. 150mg Jenny & Sue*'.

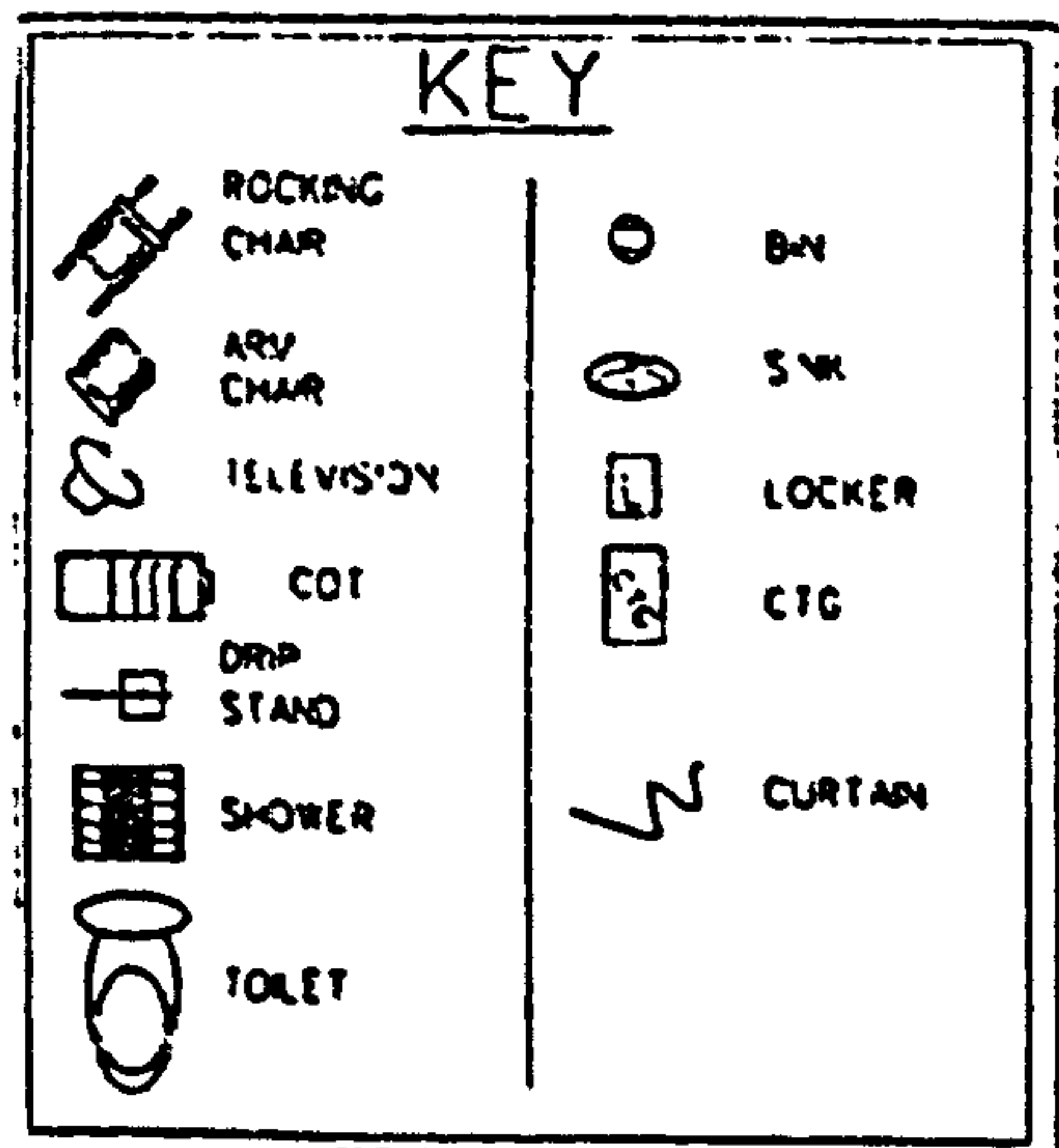
Men looked slightly embarrassed and diffident when walking through the labour ward and looked quite uncomfortable when moving through the midwives' space in the labour room. They tended to move through these spaces very quickly and resolutely. It was easier for the man to leave the labour ward if the woman was in a room on the first corridor. However they still had to return through at least one of the locked doors.

[illegible]

FLOOR PLAN OF TWO LABOUR ROOMS



KEY TO FURNITURE & EQUIPMENT
IN LABOUR ROOMS



The Birth Process

It might be useful here to give the reader an idea of the process of birth in the institution. Typically when a woman decides she is in labour she will ring in to the labour ward and announce her intention to admit herself, or she and her partner will simply arrive at the hospital either by car or by ambulance. A midwife will then admit her to the labour room. She will ask her to sit down or to get onto the bed and will direct her partner to a seat in the labour room.

When labour is described in bio-medical terms as a normal physiological process it is often simplistically described as a basic template that in fact could be considered to objectify the woman and reduce her to a birthing machine. It does not take into account the fact that women are unique individuals with their own psychological, social, cultural and emotional needs and differences that will impinge upon and affect the physiological course of labour. However the following description is given in order to familiarise the reader with the process when it is described from a biological perspective.

Labour is the period during which the cervix of the woman's uterus progressively thins, dilates and is taken up into the body of the uterus until no more can be detected on vaginal examination. Simultaneously the fetal presentation (normally the head) followed by the body, descends deeper into the birth canal and eventually the baby is born through the vaginal orifice. Midwives and doctors conventionally denote labour in three stages (see glossary). This process is achieved by means of uterine contractions. These occur throughout pregnancy but at that time are of a type known as Braxton Hicks, which is simply a painless, uterine muscle contraction and relaxation, the function of which is to perfuse the uterus with oxygenated blood. Braxton Hicks' contractions change imperceptibly at the end of pregnancy into the contractions of labour.

The difference is that the uterine muscle not only contracts and relaxes it also retracts i.e. each muscle fibre becomes slightly shorter than it was originally. The effect is stronger in the upper part of the uterus and it has the effect of pushing the fetus down into the birth canal. The uterine contractions increase in length, strength and frequency until at the end of the first stage the woman is having a contraction approximately every two minutes which last about one minute. In the early or passive first stage of labour the woman can walk about or sit up in bed or a chair and is relatively pain free and interactive. As the contractions become increasingly more painful (usually after the cervix is dilated to approximately 4cm –the active first stage) she may require some form of pain relief (not necessarily medication) and stand, walk about, sit or lie coping or managing her pain. Women may often be quiet during the active first stage either because they are inwardly concentrating or due to the effects of the administration of narcotic analgesics, or a combination of both.

The first stage can last anything from two to sixteen hours dependent on the woman and factors such as her life experiences, the number of children she has already borne and the delivery/conception interval. Likewise the perceived pain can vary from individual to individual. During this time the midwife attends upon the woman, and observes her condition and that of the fetus very carefully and uses either a Pinard's stethoscope or cardiotography to monitor the fetal heart rate. The woman may eventually be suffering an amount of pain that can seem to be unbearable. This the midwives will try to relieve by various non-pharmaceutical methods such as verbal encouragement, massage, or possibly alternative remedies e.g. essential oils, flower remedies or homeopathic preparations, and sometimes by hypnosis. Medication may be offered in the form of a narcotic such as Pethidine or offer an inhalational analgesia; Entonox, or they may suggest calling the anaesthetist to administer epidural analgesia. During this

time the woman may walk around and/or sit in a rocking chair but in the labours that I observed the woman was directed to the bed and stayed there the whole time except for walks to the toilet. To summarise the first stage is a time for waiting, watching encouraging and easing the pain.

When the woman's cervix becomes fully dilated her uterine contractions change and become expulsive in nature. This is the second stage of labour and can last anything from five minutes to three or four hours again dependent on the individual. During this time the woman actively pushes the baby out into the world. The second stage is considered to end with the birth of the baby. The third stage lasts from the birth of the baby until complete separation and expulsion of the placenta and membranes.

Conclusion

As I observed and then described the process of entry to the, inner sanctum of the labour room it became obvious that there are issues surrounding the control of entry and exit. There are people like the midwife, the doctor and the labouring woman who have a right to be there and who will never be expelled. There are people such as visitors who have no right to be there but may on occasion be allowed in. In between there are marginal figures, the partners, who are usually there nowadays but do not have the right to be there. This is reflected in the saying of some of the midwives when they say, *"We always allow the father in here - unless that is they cause trouble"*.^{fwmwint7}. This seems particularly poignant when one considers that many of the men when asked why they wanted to attend the labour said, as this expectant father did, that they wanted "to be there for her".^{en}

Surveillance is briefly touched upon in the reference to privacy of the couple; gate keeping and the panopticoid design of the labour ward and it will be explored in chapter six (Power, compliance and alliance). My brief

description of the situation of the bed and the furniture of the labour room showed how these militate against closeness and physical contact between the couple. It begins a process of separation that is complete when the father goes home and leaves his partner and baby in the hospital. As I demonstrate in chapter eight (Follow up) the act of separation was recognized by the men even if they did not all articulate the fact overtly.

Chapter Four. Beliefs and Knowledge

Introduction

In this chapter I separately examine the beliefs and knowledge of the fathers and mothers before they enter the labour ward. I then look at the ways of knowing that midwives and doctors have and the underpinning philosophies from which are developed the categories, concepts and performance indicators that inform and demonstrate their practice. Most but not all of the information comes from the interviews I conducted prior to entering the labour ward. I discuss how the fathers gain their knowledge and how they actively seek information. Some responses and assumptions seem to be based in gender ascription and its associated behavioural stereotypes. However the men come across as caring and considerate individuals who want to be there for their partners to make the experience better for them. I discuss whether they actually have the right knowledge and skills to do so later on in the chapter. Part of their knowledge seems to be gained from 'young dads tales' (as distinct from, but alongside 'old wives tales').

I then explore the women's perceptions of danger and pain in childbirth and their associated fears. They have two gender-ascribed models of behaviour to follow- one broadly biomedical and one more technical and I show how they can move to a greater or lesser extent between the two. They also have cultural expectations of their partners in terms of role and its expected appropriate behaviour.

In the final part of the chapter I examine the practices and assumptions that the health professionals make in relation to the fathers in the labour ward. I consider the basis of the philosophy underlying the categories I shall examine the differences in the world-views of midwives and doctors in relation to the women in labour and the fathers of their babies. It is

interesting to see the contradiction as Frankenberg (1980) pointed out between ideology as covert beliefs and rhetoric as overt beliefs.

The Fathers and Birth - A Step into the Unknown

In Britain today peace and production are two core values that affect our view of men. Men are valued more as producers than as warriors, and the family is presented as society's basic socio-economic unit of reproduction. For this reason the traditional link between mother and child is sometimes considered the natural one (Meillassoux 1987) and is supplemented by a suggested jural link between man and child. In English Common Law the children of a marriage have always been considered to be the children of the husband. He is the pater (and presumed to be the genitor as well) and has the rights of fatherhood. However this is changing and the concept of biological fatherhood (genitor) with attached rights is becoming stronger as can be seen in the use of medical technology in the determination of genetic fatherhood (Stanworth 1987). The men in this study thought of themselves as fathers and believed that they should be present at the birth. This belief was so completely internalised that they had difficulty in remembering or articulating why or how the decision to be present at the birth had been made. In general they considered as this man does,

"It just seemed the natural thing to do really, and I think erm, in, the kind of social and family environment and everything, or at least older family it's been the norm, you know everybody we know as friends or as family around our own age have always been, like as a couple, and been at the birth together, so it didn't really occur to me not to be, you know what I mean?" po6

When I asked whose decision it was, the couples all said that it was the man's decision.

TEXT BOX 4.1

A WOMAN'S ASSUMPTION

"I took it for granted. I just assumed you would come in. Just, have me mum for backup. Didn't I? Just in case. 'Cos I thought 'If he does feel a bit queasy.' But erm.." po7.

However on examination of their answers it was apparent that this was not always so clear cut and straightforward. There seemed to be pressures on the men from their partners and from what they perceived as cultural expectations as is seen in the above extract. Being at the birth was seen as a very modern thing to do. As one man said, *"I think now the 90's is here, obviously going into the millennium and all that, but we're a lot different to what our fathers were"*^{p07}. These issues were explored further in the quantitative questionnaires (chapter thirteen). This view of themselves as being different from their own fathers was mentioned several times as in the account of the father who said *"If I had been a dad twenty odd years ago I would still have wanted to be there when it wasn't fashionable"*ⁿ¹. Or the other who considered that in *"the old fashioned, the father was kind of out of it"*. ^{p06}

Being there for Her

They spoke about duty, obligation and responsibility in that it was seen as something they started together and would be finishing together for example *"I put her in that situation so I should be there for her, to be strong for her like"*^{p011}. There was an obligation to the partner to help and support her because *"she needs me"*^{e15} and not to allow her to go through it alone. Several men mentioned that the reason they wanted to be at the birth or had been was to *"be there for her"*^{e14}, *"just being there for her"*^{p04}. to *"support her"*^{e12} or *"to see she is alright and make her feel better"*^{e13} Or there was a sense of fairness to other children such as that of the man who said he had a daughter and was there *"cos I was there at the other"*. ^{p02}. Interestingly they all talked about 'it' as being the labour and the birth. No expectant father said anything about wanting to watch or welcome his child into the world. The baby was hardly referred to at all, and when it was, it was in vague terms such as *"the finished article"*^{e15} or *"I want to see what I have created"*^{e15}. Initially I thought this was a device of speech used by expectant fathers in order not to tempt fate, but I found that some new fathers also spoke in this way. This seems very

strange unless they cannot reconcile the naked, wet, newly emerged and bloody baby with their clean, sweet smelling and clothed offspring. It is possibly a fear of nature with all the ramifications of blood and danger. This was evident in the man who when the midwife asked should she put the baby on his partner's abdomen at birth he shouted before she could answer, " *No! I will faint if he is covered in blood. Clean him up first.*"^{p010}. Other new fathers did talk about the child. One said that being there was " *it's just you have to now really, don't you? For your own kid you have to do that. It's something that's just amazing isn't it?*"^{p011}.

It is tempting to say that because the men believe they should be present at birth then it is a social norm in England today. This could be supported by looking at the changing role of fathers from ethnic backgrounds as do Woolett and Dosanjh-Matwaa (1990) who show that Asian women from arranged marriages had their husband's present at the birth. However it is more likely that it is not yet a social norm and that the transition period from the total exclusion of the 1960's to full inclusion of men is not complete.

This is because as yet there is no social sanction on men against their absence from the labour room. Bourdieu's (1977) conception of a social norm is one where individuals' actions are governed by a rule that they will follow even if it is not in their own narrow self interest to do so. Members of the community feel no compunction against meting out disapproval to an individual who flouts a social norm. Although on a personal level these men may feel that they should attend the birth and know that if they do not they will disappoint their partners (See Text Box 6.1) they also know that it is still allowable not to attend. This being so, their wish to be there is as yet merely a cultural drift (Ensminger & Knight 1997) where the boundaries of rights, duties and authority are still open to negotiation. Apart from the duty or responsibility to be at the birth there was a strong belief that the father needed to be included in his own right.

Being there for Himself - Inclusion and Connection

In general people like to belong and to be included in a group or couple and the men in this study were no exception. They wanted to be present at the birthing process but more than that they felt they were an integral part of it. They believed that having a baby was a momentous happening time in their lives that put everything else into perspective. As one man said, *"It's an important time in your life isn't it? All these things come along and you think are important and nothing compared to birthing a child"* p012 and as another one put it *"they're our children and I wanted to be part of that. I wanted to experience it as well."* p014. and *"It's just once in a lifetime. Ain't it? Experience."* p010. There was a sense that becoming a father through the process of birth was meaningful for them and although most found it difficult to articulate just how, it came across as a feeling of connectedness and of being part of a couple and a family. One young man, perhaps the most inarticulate of the men I spoke to, brought a lump to my throat, when, in reply to my asking him why he wanted to be there, he looked at his children so lovingly and made an expansive and embracing gesture with his arms towards them, and said *"they're your children aren't they?"* p09. One man described his partner as his *"soul mate"* ef5, which conveyed a sense of integration and boundedness to each other. The sense of mystery and of being part of a new life entering the world was also strong. There was a need to be part of this for themselves but not in a selfish way but rather as one half of a functioning unit for example *"it's a joint thing isn't it"* p01. Or as this man says he wants to be there *"cos my woman's there, and I want to be there as well"*. ef4. The sense of spirituality was not usually overtly expressed in religious terms Only one man said that he considered that having children was *"part of God's plan as it were ...for marriage"* p06 and for *"raising somebody up to adulthood"* p06

Partnership and Gender Role Behaviour

In Western society there is belief in the mind/body dualism popularised in the 17th century by Descartes (Scheper-Hughes 1987) that has led to the likening of the body to a machine. It is exemplified as the so-called medical model, and has led to the creation of medical knowledge (chapter eight). The human body is symbolic of the system in which it functions (Douglas 1970) and enters into various cultural classifications from birth onward, and even before birth via its ultrasound image. The initial classification is through the ascription of biological sex and gender roles. Structural social relationships arise from these ascriptions of gender and to a greater or lesser extent predetermine social relationships. Gender differentiation and development contribute to the perception of the self and are confirmed in varying interactional situations (Deegan and Hill 1987). The men and women in this study share a common cultural background and share, as one would expect, views about specific gender behaviours. In English society, St. George, the Knight in Shining Armour slaying the dragon, and the prince awakening Sleeping Beauty with a kiss are powerful prescriptions for behaviour. Men are active whilst women are passive, men are strong and women are weak. The underlying message is also about how to conduct one's sex life. She in particular is to be virginal and to be faithful as part of the 'happy ever after' myth. It could be expected that the men (and the women) in this study had fully taken on board the beliefs inherent in these gender rules and this was reflected in the expectant fathers' anticipation of their role in the labour room. The men believed they would be there to support, calm and make their partners feel better. This was evidenced in some of the reasons given below. The image they projected was that of the strong protector who would shield her from harm. This was not the case with the men who had been through the process already. They now had experiential knowledge, were socialised into the labour and birth setting and their view was quite different as I describe below.

Expectant father No.1

Being quite reassuring and knowing that you know you are there if you are needed to calm them down and if there are any problems there is someone for them. Specially for Y I just want to be there if there are any problems. So maybe a little of each, a bit of reassurance and a little bit of being told it is time to go into hospital or it is not.

I think I'll be able to calm her down a lot more. I think she will be very nervous. If I know Y, she will be very nervous. I think I'll be there to calm her down. I think I'll be there for her.

Expectant Father No.2

R. How do you think you will affect your partner when she is labouring?

EF2 Probably I'll be a punch bag!

Expectant Father No.3

I'd expect to be there and see that she's all right and make her feel better.

Expectant Father No. 5

Er, to hold her hand, to try and comfort her, make her feel better, because I know she's going to be uncomfortable and whatever, all that she wants me to do. I know she'll probably shout and bawl at me like, me, like mum did with me dad when I was born like, but it's one of those things isn't it?

The impact of male doctors in the labour room was skirted around by most of the men but two of the expectant fathers were more explicit about their fears. One worried about how he would feel about male doctors because he had *"not really seen a male doctor with the head between the legs"* EF1. The other was particularly interesting in that (See interview below) he was trying to be objective but in reality was actually revealing quite a lot about himself. He identified that his partner belonged to him, she was his, and he was the only person who had touched her before the doctor. He watched the doctor very carefully and did not like what he saw. He was horrified, and suggested that he had that feeling because of the way the doctor was touching his girlfriend. He implied a sexual motive to the touching, which he quickly corrected by referring to the

benefits of the process to his girlfriend and their baby. It was intriguing that he said he didn't know the doctor. One wonders what difference this would have made to his feelings. He was very sure that he was going to be there all the way and would be protective. However I wasn't sure whether he was protective of her as a person or as his girlfriend because he refers to her in the abstract as something that means a lot to him. He was voicing the whole of the stereotype, the watchful male, guarding his reproductive rights and offspring and being potentially aggressive to other strange, intruding males.

Expectant Father No. 5

They were going to do like a smear thing with her just to see how much was actually in her water, just to check her out and I were actually, I was present in the room when they were doing it. And it's the first, I mean I know about smears and what women have to go through, I mean I couldn't put up with out like that myself like, but I was still there when they carried the examination on her, and it, it didn't, she laughed when she looked at me when the doctor you know were doing what they were doing and midwife were there, she just looked at me and laughed because she said your face were a picture. You know like horror, like ahh, as if what's he doing, you know but, I were there and I'll be there all the way.

R So why were you horrified?

I Not horrified but just like.

R. An invasion of privacy?

I. Yeah. And it were like, she, she's mine, future wife, or she's you know my, she's like me soul mate and it's like someone touching her in a way that really only I've touched, you know that kind of thing like this guy I've never met him before and all that, but I mean he's, he's only doing it for her own good and her own well-being and the baby's own well-being, that's why I was a bit miffed by it all.

R That was one of the questions I was going to ask. Do you think erm, that the presence of men in the labour ward would affect erm, R at all?

- I *I wouldn't have thought so not after, I mean she's been, prodded and poked and pushed when she had the amnio.*
- R *But you think it might affect you, you think?*
- I *Not really, I mean it depends how bad the labour actually is, you know if she's in a lot of pain and that, I'm probably, well, I wouldn't say I'm an aggressive person, but if someone's hurting something that, that means a lot to me I might get aggravated in that, not like I'm going to hit anyone but you know they'll get my point of view like, speak from the mouth you know.*

Overall the men thought that through their sexual partners they were going to become fathers, which meant a change in their role, social status, duties and obligations.

Men's Knowledge and its Sources

Intellectual and Social

In any belief system there is an assumption that there is knowledge to be understood and for various domains there can usually be more than one way of knowing. The phenomenon of childbirth can be viewed as a social or medical event dependent on one's point of view. Within the two paradigms are several very different concepts of knowledge. There is medical and midwifery knowledge (which I discuss below) and experiential and mediated ways of knowing. Within hierarchies of knowledge the most prestigious is the authoritative knowledge and the most important aspect of this is as Jordan (1993) says it *"is not that it is correct but that it counts"*. Authoritative knowledge reflects the power structure of the social setting and in the case of Westernised childbirth the authoritative knowledge is that of medicine. Medical knowledge is positivist, rational, scientific, objective and masculine. Its ascendancy reflects the power structures of medicine in society. The authoritative knowledge is that which is used to make judgements and justify decisions and actions in clinical practice. The embodied knowledge of first-time mothers is used by them to make decisions about their own care from when to go into hospital, through the positioning in labour and

the acceptance of pain relief to the pushing and deliverance of the baby into the world. In later births experiential knowledge is also brought into the decision-making process. There is often a tension between the two types of knowledge with women oscillating between compliance and antagonism towards the authority and knowledge of medical and midwifery practitioners.

Fathers are in a different position in that they have neither authoritative nor embodied knowledge of childbirth although they can accumulate experiential knowledge in second and subsequent birth experiences. Women have long relied on other women for assistance in childbirth and the existence of a female lateral sharing of knowledge is well documented (Trevathan 1996). What is not so clear is, how men as first-time fathers acquire knowledge and what is valued. However if one expands the understanding of knowledge from that of, being specifically information to meaning a wider understanding and awareness, then men can and do have knowledge. They know their partners and they can have an intuitive understanding which in this case I take to mean the faculty of immediate cognition of their wives' state of mind and body not necessarily based on reasoning or perception.

What do they know and how do they get to know it.

The major message surrounding the actual process of childbirth is that it is dangerous, painful and frightening and this message is transmitted to men from friends and family. In this study one man appeared to try to disguise his fear and seemed to be asking for reassurance when he said that a friend of his thought his own wife was going to die having the baby. He said (with a laugh) *"although you can laugh now it must have been hell for him at the time"* Ef1. He was still seeking reassurance when he said, *"I mean I don't know what to expect really. I mean is it going to be very bad pain?"* Ef1. The fear was sometimes projected onto their partner and discussed in a second hand fashion by saying that the woman was frightened. The concept of danger was not unfounded, as one expectant

father knew as he recounted his wife's history of twelve pregnancies that resulted in only one live child.

The two main triggers of fear in the fathers were, the sight of blood and the worry that something was going wrong. It was quite difficult for the men to admit they were frightened by the sight of blood and the information was sometimes relayed by his partner such as when F said *"He was squeamish and didn't like blood and that"*_{po15} and another *"he didn't like what he saw, 'blood and things'"*_{nm2}. If he overcame his fear it was seen as worthy of praise as this woman says proudly *"he was better than I thought he would be. He was. 'Cos if he'd seen the sight of blood or anything like that, for him to stand there and put my leg on his shoulder while I was...."*_{po2}. It was also commented on by the staff, for example, the doctor who talked about *"all these big tough guys and all of a sudden they're presented with their wife up on stirrups, blood and guts and they just don't know what to do"*_{dr1}.

Some did however admit their fear like the new father, who said, *"When you see the blood, and you see the needle, cos er it just does er tend to worry you"*_{po7}. Another like this man acknowledged his fear but dismissed by saying *"I mean I wouldn't faint you know or anything, but I just don't like blood you know"*_{po12}. Another man who said, *"It's not the blood you go for"* echoed this dismissal. *It's the delivery isn't it, and the fantastic little human?*_{po15}.

Although the safety of mothers and babies in childbirth has improved things can and do wrong in labour and delivery. Babies can be left brain damaged or die and women can be traumatised and also they may die. Men do fear something going wrong and so are vigilant even though they may feel helpless, as does this man who describes how frightening it was for him to hear the fetal heart rate decelerate with the contractions.

"When she was having a contraction he would go.. They didn't seem too concerned, the midwives. But when you could hear it. For Joe Public like ourselves when you can hear a baby going bum.....bum.....bum.....bum. It is a bit frightening!" Nf2.

Lack of knowledge was instrumental in making the men feel scared. A fear of the dangers inherent in childbirth was expressed over and over again in different ways as they talked about the possibility of complications or problems and the woman's fears and reluctance to go through it. I got the impression that the men could not conceptualise their own dread. They knew it was frightening and dangerous but just how they could not say. They did not openly articulate just what the danger was and very few (whether expectant or new) fathers, if any, seemed to have any idea about the physiology or progress of labour. This was so even if they had attended antenatal classes, although they may not have realised this, as this man doesn't when he says,

"I don't think there is any kind of medical things I need to know. Maybe dilatation and that kind of thing I need to know and how many minutes which I have a rough idea about now but is the kind of thing you tend to know more about as the time nears really." Ef1.

Family Myths and Legends

Although fear of childbirth is not unreasonable, it can be made worse by informants. One woman had a family history of a maternal death and as her partner said,

"I don't know how far back we're going now, but of the, like, her ancestors, the mother died in childbirth and she's told me ever since I've met her that she has a recurring dream that it's going to happen to herself, like, so, she's not, I think, you know, she don't need anyone telling her it might happen to her or it might happen to the child, you know what I mean, like that, so. Ef5.

Another method of relating childbirth stories is by the friends or family who talk about the pain that their wives have been through as a way of

offloading and/or debriefing for themselves. For example one man talked about the shouting that his mother did to his father. *"She gave loads, me mum when she was having me"*. However it is notoriously difficult to conceptualise pain as Niven (1985) found. Women themselves find it hard to remember just how it felt so it is likely that the memories of these fathers as revealed to other men contain a mixture of remembrance of their own fear and their observations of their partners' pain. There was a feeling of hopeful optimism in that the men considered that they were going to go into a stressful and dangerous situation but that on the whole they would know what to do. It would just come naturally.

Official Knowledge

Parentcraft classes were in theory available to all the men but in practice I found that few had attended them. Those men that had done so generally considered them useful in that they said they found the classes enjoyable and interesting but they made very little comment about the appropriateness of the content. The timing of the classes evoked more comment in that they said that they were either too early or too late in the pregnancy. If they were too late then knowledge had been gained from elsewhere but attending could concentrate the mind *"the context got you into, like, the final process, like it is going to happen"*. This man considered that if a person read a book early in pregnancy it might not register. He was describing the way he had pushed the pregnancy and the birth to the back of his mind as something he could not see as real. But by having late parentcraft classes, *"the fact that it was right at the end and the fact that you were in the hospital in a sense slipped your brain into the present and you didn't have long to train"*. Jordan (1990) found that men go through distinct phases in their partners' pregnancies. These move as a continuum from, sperm donor of a potential baby, to father of a baby where the fetus is considered an actual person. It seems probable that their receptivity to parentcraft classes depends on where on the continuum they are when the offer of classes is made. When they

didn't go the reasons put forward were varied from *"I got the impression that parentcraft classes were mostly about the birth, and you know, your breathing techniques."*^{p014}. to the fact that men were only invited to one class and the particular man was away, and included such reasons as they hadn't been told about them and *"my mum never went to parentcraft class and her mum didn't go, so she, you know, well, well we don't need to go."*^{e75}. The overall impression was that men thought they were about being a parent and if they had a previous child or if they came from a background of contact with young children then they did not see a good reason to attend. This was especially true for one man who considered himself a good father and was quite annoyed with what he saw as the midwife's patronising manner when she said "Come on you dads it's time you learned how to make a bottle". There was also an element of embarrassment in that they thought they would have to do exercises with their partners and there would be *"legs and all that in the air"*^{e73}. It was also commented that it would be useful to have all male classes situated in the evening, off site and run by a man. Then questions to do with male fears and personal issues such as, whether they could have sex or not in pregnancy, could be asked and answered without discomfiture..

Media Knowledge

Depending on their skill in information retrieval men gained quite a lot of knowledge from books, magazines, newspapers and television and videos. However this was very variable both in content and level. Some men were adept at gaining information this way and were quite confident in the knowledge they had acquired whilst others although acknowledging that the information was out there, admitted that they had not read much. These men also did not seem to have gained much from television or videos. However there were several comments from the expectant fathers that they would like to be able to borrow videos from the hospital to watch at home.

although men are still free not to attend it is becoming more and more expected of them, particularly by their partners. In other times and other cultures men have remained outside the labour room. They were outside performing couvade rituals, which according to Bettelheim (1955) are ultimately about ensuring that the father is not excluded from the social aspects of parenthood. Couvade according to Rivière (1971) involves the father giving up his normal behaviour and following ritualised behaviour such as *“social confinement, sexual restraint avoiding physical labour and certain types of food, and even imitating birth through mock behaviour.”* It is easier to observe couvade in societies that are markedly different from our own but according to Summersgill (1993) there was a time before hospitalisation for birth when men in this country performed couvade rituals. They consisted of chopping wood, building fires, boiling water and generally assisting in the birth preparations. Summersgill (1993) proposes that fathers have been marginalized by the admission of their partners to hospital and the ‘pretend’ roles they have been given. However this might not actually be the case. For if one goes back to the definitions of Rivière it can be seen that they are doing all of them except the imitation of birth. They are being socially confined, avoiding physical labour, and even eating certain types of food. It is possible to see them going into the labour room with their partner as couvade behaviour.

They believe that they are going to be included and will ‘there for her’ as well as for themselves and have taken on board the cultural beliefs associated with gender ascription in a Western society. They are in the labour room, looking out (or rather in) for her and their baby. They find the potential presence of other males confusing and in relation to themselves ambiguous. Kitzinger (1980), and Moran (1989) identified that the lack of knowledge, the limited role and the denial of any significant role to play marginalized the fathers in the labour room. There is also a belief (Bedford and Johnson 1988) that fathers have taken on a sub cultural belief that possible involvement with labour and birth

would threaten their masculinity and virility. The opposite was found by talking to the fathers in this study. Their assumptions about how they thought they would behave were consistent with the stereotypes of the aggressive male watching over a weaker and vulnerable female. There is a suggestion that the sexual relationship is affected by having a baby but it does not seem to be because of a threat to the man's virility (post delivery interviews), but rather to the logistics of having a baby or toddler in the house. It was apparent however that although they believed that birth was dangerous, painful and frightening they actually did very little in the way of acquiring knowledge with which to make it less so. This may be because of a somewhat naïve belief in their own ability to cope compounded with a lack of useful, user friendly information from the maternity services.

Mothers' Beliefs and Expectations of the Father

Danger, Pain and Fear

According to Davies Floyd (1992) the holistic view is the opposite of the technocratic model. It holds that the family is the significant social unit, that, the mother and unborn baby are an inseparable and interdependent whole and that pregnancy and birth are natural processes that science will never supplant (Davies-Floyd 1992). Birth is something we can seek to learn from and know but which we can never control. A core of the belief is that the pregnant woman is in a normal social and physiological state and should not be judged to be sick. She is also an individual with the right to make her own decisions and choices including the nature of and identity of the personnel who attend her. She is the main player, she gives birth and the role of the attendants is to care for, and empower, her to give birth naturally.

The women in the pre-observation interviews seemed however for the most part to tend toward the technocratic end of the continuum. They had all been through a fully medicalized antenatal service and one or two had actually been hospitalized earlier in the pregnancy. They nearly all

gave the impression of being unquestioning about the general aspects of their care, for example, when they talked about the possibility of having a caesarean section or an epidural analgesic. This woman for example talks about how she was told she needed a caesarean section.

*'They said. "You are not achieving anything here. Do you have any objections to a caesarean?" I just. They said, "Do you want to go to sleep?" I said, "I prefer not to, but I just want the baby out."'*Nm1.

Women had become fully involved with the medical model rather than merely accepting its extent. None of the women gave me a sense that they had been empowered or thought that birth was a natural and wonderful experience. They did not talk about the wonder and joy of having a baby at any point although they did talk about wanting *"a well baby."*Nm1, pw1. It seems that they had taken on board the cultural belief that birth was dangerous and frightening and that hospital was the safest place to give birth. Their rite of passage had been via the technocratic model (Davies-Floyd (1992) and they were accepting and unquestioning. They, in fact, concentrated on pain and fear as two consistent themes. This too reflected one of the central tenets of the medical model. These quotations from two women are typical in that both considered their contractions to be painful and that they needed medical intervention to help.

New Mother No.2

I had an epidural. At the start. As soon as the contractions started they put me on an epidural.

R Was that okay?

Yes. I needed them.

New Mother No.1

I need to cope with it myself and let medical intervention take over when I can't.

The women 'knew' that labour would be painful and gained that knowledge from several sources. One was their previous experiential

knowledge of birth. So if they had undergone the experience there was the lived (or perceived) reality. Another source was what Pearsall (Stanworth 1987) calls the underground network of mothers. Pregnant women share their experiences and through them they make sense of the medical and midwifery advice that they are given and the feelings that they have. They then use this networked knowledge as a base for decision-making, for example, about whether to have a scan or not or whether to worry about weight gain in pregnancy. Davies- Floyd likens this solidarity between women to the *communitas* described by Turner (1990) as part of the rite of passage although she qualifies it by considering the women's network as being rather more structured than the original concept. The third source, probably most committed to the idea of pain in labour, is formally transmitted knowledge. Most forms of antenatal advice from videos, books, magazines and parentcraft classes, suggest that birth is painful but can be coped with by breathing 'correctly' or by being given pain relief of some sort or another by an expert namely, a midwife or a doctor.

The women were nevertheless frightened of the pain. The message that birth would be painful had been received and understood. The second part about being able to cope had been less assimilated. They had very little compunction in expressing this fear. *"I was frightened"* and *"that was pretty scaring. I was very, very scared"*^{Nm1}. Or *"if I'd had the chance to run I would have just run"*.^{Nm2} Even having the pain relief can be frightening as this mother thought when she compared having an epidural inserted as *"it's a bit like, your having an operation aren't you. So it's a bit frightening. More so than labour 'cos you know you are being operated 'on"*.^{Pw4}.

They did, however, give the impression of seeing themselves as social and individual beings with the right to choose their own companions. This came across in the answers to why the partner was to be or had been present at the birth. Although it was treated on the whole as a naturally

occurring and taken-for-granted decision there were instances of the woman's specific influence for example in Ian's reply *"Cos she wanted me to sit with her"*^{p09} or as Mary says *"I decided for him"*^{p012}. There was neither discussion about the choice of birth attendants nor any about the possibility of home birth. The assumption was that the birth would or did take place in hospital and that the midwives and the doctors were there to control the pain and intervene when necessary, so in effect, despite a veneer of choice regarding attendants the women subscribed overall to the technocrat model.

Women, because of menstruation, are not unused to the sight of blood and it did not seem to hold the same terror for them as it did for the men. Although there was one woman who described to me how she was quite surprised at the amount she had lost after the delivery.

"I kept saying, 'I'm wet, I'm wet and I thought I was sweating because obviously you're nervous and that, you're wet, 'I'm wet, I'm wet'. Anyway when they'd actually took him away and they'd started cleaning me up they took this gown off me and I looked at it, and I thought 'Oh my God! I didn't realize I'd lost that amount of blood. I was absolutely saturated.'"^{p014}.

When they did talk about blood, it was, as we have seen, more in relation to the anticipated feelings and reactions of their partners.

St George or Little Georgie?

The women seemed to be quite ambivalent in their perception of their partner. They often seemed to think of them as weak and squeamish characters that needed to be shielded from the distressing aspects of the labour such as pain, blood and body fluids. Yet at the same time they considered the men to be there as emotional and moral supporters. One woman I think was quite disappointed because she thought they would be a team but when it came to it she felt he needed protection rather than partnership.

"I think I was putting him off really. I think we thought we would support each other but when it really happened I, sort of, back off type of thing because I think he doesn't have to go through with it, I do. So, some of the things they were doing, the examinations and stitches and things like that I said, "go out". No I didn't want him to see that side of things. He is quite a worrier. It would probably upset him as well seeing it"^{nm2}.

This was echoed by other women who said *"my husband is very good but when I went into labour with my second baby he went outside"*^{qpw1} and *"my partner could not handle the labour and birth and I personally found his presence reassuring but his actual hands on experience was of no use as I think the whole experience was such a shock to him"*^{qnm10}.

On reflection it might be that they were not being ambivalent about their partner but merely demonstrating the two opposing sides of woman's gender stereotypes. For a woman can be allowed to be both strong and maternal with the caring and protecting behaviour that goes with it or she can be the weak and helpless princess waiting for her prince. This latter behaviour was evident in the reasons given by women for wanting their partners in the labour room with them.

Her needs

The belief that the man should be there was surprisingly strong considering what we know to be the short history of the practice. His role was to care and to give moral and emotional support. Because the structure and context of birth was perceived to be frightening the woman needed to have someone with her to comfort and reassure her. It was strange in a way that she thought this person should be her partner because one could assume that this was the role of the midwife. Midwives are very proud of the fact that the word midwife is derived from the Anglo-Saxon 'mid' meaning with and 'wif' meaning woman. Their whole *raison d'être* is supposedly encompassed by this meaning. Obviously in practice this has not filtered out into the consciousness of the women themselves, so perhaps, as will be examined later, there is

more rhetoric than practice base (or more desire than authority) to the ideology.

When the movement to hospitalize women for birth gained momentum their physical needs were given priority and their emotional needs were seen as fairly irrelevant as can be seen in the extract from the Association for Improvement of Maternity Services (A.I.M.S.) newsletter of 1961.

Hampshire. Mrs Wolfe writes,

"Our campaign in Hampshire has up to now been directed against the appalling conditions and general lack of humanity existing in the maternity department of St. Mary's Hospital. Portsmouth. Last January (mentioned in the previous Newsletter) Mrs Gill from Petersfield accompanied by Col. Fletcher met some members of St. Mary's Hosp. Management Comm., as a result of her letter of complaint after her confinement. This letter was discussed in detail and the Management Comm., while acknowledging that the unit was very understaffed and the physical conditions there were poor, stated that they were not responsible for the mothers' emotional state, and considerate treatment could only be expected by private patients. Tempers became very heated, and no good came out of the meeting. ... The latest news is that fathers are now admitted during the first stage of labour, there are earphones installed in the Rest Ward, and strictly unofficially many of our suggestions have been accepted by the Ministry."

AIMS Newsletter No 5, Sept 1961, p8.

A.I.M.S was very concerned about women labouring on their own and lobbied for them to have a companion with them to ease the loneliness. Initially the members thought that this would be a female companion but were surprised to find that progressive hospitals like Charing Cross had interpreted this to mean the husband. As the quotation from A.I.M.S. newsletter No. 2. 1968 shows that it was still thinking that the presence of the husband is about banishing loneliness and that anyone could do the job.

"Husbands are welcomed in this hospital (Charing Cross) and are invited to stay with their wives during labour - If a husband cannot come, a 'substitute' is provided in the form of a student doctor. Unwanted loneliness is therefore eliminated."

A.I.M.S. Newsletter 1968 2 2.

The women I spoke to were not just (or not even) talking about loneliness. Although one *pw3* said she wanted her husband to be there so she would not feel so alone. Sometimes, however, they wanted their mother or other female relative there as well, although the main person they wanted was their partner. As one woman said, *"I wouldn't have had anyone else. I know other people who have had a mate in or something but I don't think I would have done. It was him or nobody."**Nm1* and *"I'd rather have him than anyone else in there"* *pw4*. He was there to give her *"reassurance, confidence, comfort, encouragement and support."* *pw1, pw2, pw3 nm2 nm1*. The support was to be *"moral and emotional support really rather than anything practical"* *nm1, nm2* and *"someone to hold my hand or grip hold of or to say you are doing fine"* *nm1*. There was a confidence that the men would fulfil the role well. As one woman said he was there *"to make me calm"* *pw2* and *"he kept me strong, he kept me going really, you know, I couldn't have done it without him"* *po11*. Another woman echoed the men's responses when she said he was there *"to be there for me"* *pw3*.

These reasons show how strongly the women had taken on board the consideration of birth as an ordeal to be endured, in which by implication they might suffer discomfort, become distressed and out of control, lack confidence and feel weak and powerless. The baby was hardly mentioned except for one woman who said *"Oh just knowing that he's there, just him and me. I've just got to see him holding the baby, is brilliant and all is well."* *pw5*. None of the women expressed confidence in themselves as having an innate ability to nurture their pregnancies and birth their babies, as they might have done, if their belief system was congruent with the holistic model. Within their model of belief they were going through

an unsafe process in a strange but safe environment and so needed a strong helpmeet, one that would support them through it. So even before they entered the maternity unit the women had given away their power. They had made themselves powerless. Their own embodied knowledge of pregnancy and perhaps a previous birth had not strengthened them but merely confirmed the dominant view that their knowledge was of little value. This is in accord with Foucault's (1972) view that dominant knowledge serves to 'function as a normative power' with 'the judges of normality everywhere' and with 'a certain policy of the body' which renders groups of people docile and useful.

Behavioural expectations

The women found it quite difficult to identify what exactly they expected the man to do in the labour room. They were as vague as the men had been in some ways in that they expected him to be there for them. They were unsure of how the men would actually behave and as one woman said "*it depends on the type of man he is*"_{pw5}. The types were not openly articulated but examples of expected and approved behaviour were given. They had to appear interested and not be aggressive. They had to be involved and please the midwife by helping her and could transmit information between the woman and the midwife. They had to be "*fairly sensible and astute*"_{nm1} and they were to "*stay in the background and not get in the way of the professionals*"_{nm1}. They were not to stand up and pace up and down as this made the woman anxious. The women's expectations were quite low or as one woman said she expected him to do nothing_{pw4}. They reiterated that their partners would be there to comfort them and to make the time pass more quickly. For example by having "*him to talk to her*"_{pw5} and that "*having him there will make the situation better*"_{pw4}. Although they expected little, the women confirmed over and over again that it was important to them that their partners be present. One woman said that if she had to have a caesarean section she would

have an epidural rather than a general anaesthetic so that her husband could be present.

There are a number of studies that measure women's confidence in their ability to cope with labour (Walker & Erdman 1984, Crowe & Von Beyer 1989, Lowe 1991). These all propose various strategies to measure the phenomenon e.g. Crowe & Von Beyer's visual analogue or Lowe's self-efficacy inventory. However what they are all based on is, as Lowe describes it, the 'potentially aversive event' of childbirth, and the belief that women develop coping skills to deal with it. All the women I spoke to in this study seemed to agree with this assessment which I consider to be objectively strange. When one looks at the statistics (DOH 1998) it is obvious that childbirth both for the mother and the newborn child poses relatively little risk. Where there are adverse outcomes they are related to specific risk factors that are found in relatively small numbers in the general population as Tew (1995) demonstrates. We live in a risky world, one in which we can step out of our front door and be killed by a passing car or be attacked by a robber. However what most people do not do is live in dread of these things. They on the whole assess the degree of risk and its forms and take avoiding action when they feel the need. Programmes, like Crimewatch on TV, do put over some fear but are at pains to tell the population how rarely the events occur in 'real' life. This is not the case with childbirth. The message is always that it is painful and potentially very dangerous. General practitioners on the whole do not approve of women having babies at home and are considered by some (Tew 1995 p15) to be acting thereby in an '*unethical and reprehensible manner*'. She writes that '*they frightened women by exaggerating the dangers of confinement at home or in a general practitioner unit*'. These women have soaked up the message and it is well ingrained. A reversal seems unlikely despite the efforts of the Natural Childbirth Trust (NCT) and the Association of Radical Midwives (ARM) to counter this as

propaganda. This is because the alternative message is now 'out there' in the information network of pregnant women and new mothers.

Because they think childbirth is so alien, dangerous and frightening the women need a champion to accompany them. This has to be their partner because although they can, and sometimes do, choose their mothers and female relatives or friends to go with them as well, the two categories are perceived to have different roles. Women seemed to see their mothers as being carers and practical people on the whole, but people who might act in a female way, for example a mother might not be assertive and *" I think she would panic, make me panic more."*^{po10}. Although they do have reservations about the men because they know them to be somewhat squeamish and frightened, on balance they want them there to protect them and make them feel safe and strong. Whether it is possible for men actually to do so in the maternity unit setting will be discussed in more detail below.

Midwives' and Doctors' Belief Systems of Care

Some Aspects of a Belief system

Philosophy is an academic discipline that concerns itself with making sense of nature and the structure of reality. It makes explicit concepts of meaning, the construction of knowledge and moral judgements and relates their significance to both ordinary and to scientific belief. There are a number of approaches to thinking about reality including 'religious traditions, Marxism, existentialism, and phenomenology' (Bryar 1995). Epistemology, (how we know that we know what we know) questions knowledge itself (Dancy 1985) and whether beliefs are justified or not. It is still necessary as a midwife, to explore briefly the philosophical belief systems of medicine and midwifery. Concepts, derived even unconsciously, from an underlying philosophy are the building blocks of the structure of practice. Or as Pearson & Vaughn (1986 p8) put it,

"So philosophy can be interpreted as the pursuit of wisdom or knowledge about the things around us and what causes them. A philosophy is an explicit statement about what you believe and about what values you hold. These values and beliefs in turn, affect the way you behave."

The philosophy of medicine or the dominant Western biomedical model is based on views of the body as organic in that it functions naturally and nature takes its course and the so-called Cartesian view of duality of the body and mind. This in turn is based on a metaphor of the body as a potentially defective machine made up of body parts, which in optimum conditions will be running smoothly (healthily). Deviations from the normal may call for intervention by a doctor who, by diagnosis and treatment will identify and cure the cause of the illhealth. The individual is the 'patient' who is dependent on the doctor and will more often than not, at least in the short term, be cured. The power to cure comes from the scientific principles on which the belief rests. Individuals may also believe in a God who allows the scientific knowledge to be revealed and who may cause the 'cure' to fail or to succeed.

There is a power imbalance between patient, and doctor and midwife.

The task of the patient is to learn to read the signs, accept the symptoms and understand the symbols, which correctly read, reveal the limits not only of healing ability but of power and control derived by the individual from his/her category and its permitted level of information.

Frankenberg 1980

As a profession becomes more specialised a consensus of agreement develops concerning its knowledge base (Bryar 1995). Biomedicine is a typical example of this and its

TEXT BOX 4.2 THE VISION (ARM 1986)

- *The relationship between mother and midwife is fundamental to good midwifery care (20)*
- *The mother is the central person in the process of care (21)*
- *Informed choice in childbirth for women (22)*
- *Full utilization of the midwife's skills (23, 24)*
- *Continuity of care for all childbearing women (24a, 25, 26)*
- *Community based care (6, 15a, 20)*
- *Accountability of services to those receiving them (4)*
- *Care should do no harm to mother and baby*

knowledge draws upon the physical sciences of anatomy, physiology, chemistry and physics. It seems that now the most valued methods of knowledge acquisition are seen as being gained from positivist and rationalist methodologies such as quantitative, double blind randomised controlled trials with primary outcomes. This is quite a recent development having become more and more prominent over the last fifty years.

Midwifery is in the process of moving away from the bio-medical model and developing a specialised knowledge base that is unique to itself. Its primary (but not exclusive) belief system is based on the assumption that the mother is the central person in the process of care (ARM 1986) and pregnancy and childbirth are normal social life events (Walton & Hamilton 1995). Midwifery beliefs tend to be written as philosophies of care rather than as worldviews about the nature of the body of the woman. Midwifery care is diverse and its knowledge base is eclectic, underpinned as it is by sociology, psychology and philosophy, as well as

biology and chemistry. It is also informed by the lay knowledge of women themselves. There are several ways of expressing the philosophy of care (RCM 1987, ARM 1986, Dept. of Health 1993). Overall it is that for the majority of women childbirth is a normal physiological event which requires midwifery support and care and during which they should be the focus of care and be offered choice, control and continuity of care and carer. (Walton & Hamilton 1994).

The concepts that arise from a certain philosophical stance are the encompassing categories that underpin the system. For example in medicine there is the concept of disease with its causative organisms and its processes. One is required to identify the disease, scrutinise its causative organisms and then apply a counter measure. If one deals with the condition at an appropriate stage of the process, then the patient will be cured. It is an 'if/then' approach. Another concept underpinning the biomedical model is that of scientific objectivity. This provides the rationale for using the latest technologies and also for objectifying the person. The determination to reduce bias necessitates a reductionist approach with the patient being the passive recipient of care. Information (particularly in double blind randomised controlled trials) is restricted and the person is 'done to' with little if any active partnership. Two of several concepts that underpin midwifery are those of care and support. It is not as easy to identify the meaning of care as it is for cure. There are individual writers such as Silverton (1993) who identify it as being responsive to the needs of mothers and families and with practice based upon sound research. Others see it as a personal relationship by which the professional skills of the midwife are utilised competently and to the full e.g. (Flint 1989). Support is another concept, which is not easily identifiable. For it can refer to physical, social or psychological care or indeed all three. An easier concept to define if not to achieve is that of safety. Safe practice is one that causes no harm to the mother and the baby and is implicit in the Hippocratic oath of the medical

profession (appendix four) and the Midwives' Code of Practice and Rules (U.K.C.C. 1998).

Performance Indicators.

Once the concepts that underpin a philosophy of care have been identified and defined it is then possible to form components and groups of performance indicators from them. These form the basis of working practice and are measurable outcomes of performance. For example the concept of safety can be broken into components such as 'performs early baseline measurements at antenatal booking clinic and each visit thereafter', or 'the doctor will see each woman at least once in pregnancy'. The performance indicators for these would be actions such as 'clear history taking', and, 'all tasks appropriate to the examination is undertaken'. The performance indicators symbolically point to the prevailing belief system in that they indicate what is held valuable and what the underlying discipline is that informs the concepts and the philosophy.

Underlying discipline

As we have seen the underlying discipline informing the concepts is also that which supports the belief system. So in a model such as medicine where technology is held in great esteem one would not be surprised to find that the prevailing science is biochemistry or physics. This model ensures that the woman's body is objectified. Life signs deemed to be worth monitoring for example blood pressure, pulse, and fetal heart among others will be measured using technology such as the cardiography monitor. As long as her body parts are functioning according to scientific principles or 'norms' then she may be considered as making normal progression in labour (the body-organic model). Nature will take its course and she can be left to the care of the midwife. Her family is not considered at all because in this model it is largely irrelevant.

In midwifery where choice is considered a valued concept then the underpinning discipline may be one of the human sciences such as psychology and the desirable skills may include those of communication. The 'problem' with a concept such as choice is that it puts the decision-making into the hands of the woman, and women may use different measures of risk. For example a single mother who is deemed to be at risk of placental abruption and haemorrhage in the antenatal period may according to the biomedical model be judged to be safer in hospital. However she may feel that she has to remain at home for the wellbeing of her other children. A midwife who values the right of women to choose their own care would give the woman the facts and arrange for as much support as possible to enable her to cope with her decision whatever it might be.

Practitioners apply the science that seems most relevant to their practice in order to inform their skill base. Medical practitioners use the findings of scientific research to inform and develop the clinical applications of diagnosis, medication and surgery. Usually the doctor concentrates on a particular part of the anatomy e.g. the pregnant woman's abdomen and is not too concerned with her expectations of care and worries such as her ability to cope as a mother. Until recently there has been an emphasis on quantitative research involving large sample populations with findings that are considered generalisable to the wider population. However there now seems to be a slight shift towards qualitative research looking at the meaning of situations and of illness to patients (Silverman 1993). Narrative-based accounts (Greenhalgh and Hurwitz 1998) that enrich the medical accounts of 'conditions' with stories that tell the lived experience of people in the situation today are also sometimes seen as of value.

Midwifery is relatively new to the use of research to inform its practice and is still in the process of establishing its respectability and independence in research terms (see the recent debate in the *British Journal of Midwifery* [Walsh 1999, Bates 1999]). Walsh's suggestion is

that midwifery research is dominated by an obstetric led agenda which is manifest in the use of the 'trial' and that midwives are working for obstetricians under the guise of 'teamwork and multidisciplinary research'. The implication is that midwifery research should not involve trials and should be carried out only by midwives. Bates who is not convinced that the goals of obstetricians and midwives are entirely the same supports this. She suggests that women and midwives should *"seek liberation from the obstetric ties that bind us to a medicalized view of the birthing process."* This ambivalence is reflected in the application of science to underpin practice. There is a leaning towards the prevalent sciences of medicine by midwives who adopt the biomedical model and the social sciences by midwives who support the concept of holism. In practice individual midwives tend to be somewhere along a continuum between the two in their philosophy and belief system. The maternity service, however, and its policies and risk management strategies leans heavily towards the biomedical model.

By examining the thoughts of the midwife and doctors towards the fathers in the labour ward I hope to have gained a view of performance indicators they use and move thereby towards an insight into their philosophy of care.

Doctors' Beliefs about Fathers in the Labour Ward

Doctors' beliefs naturally pointed to their adherence to the biomedical model in that overall they had no expectations of the presence at all from the fathers in the labour room. The fathers did not affect the doctor's practice except perhaps to help the doctor to have more control over the woman. As one doctor_{dr1} said, *"you just use him if you can"* and the father does not increase the control the woman has over the labour for as this doctor says, *"I would say it is the other way round and it increases the control we have over the labour."* Although all the doctors said that the presence of the father made no difference to them or to the care the mother received one did admit *"that occasionally it can be a bit awkward."*

*Some of them try to watch while you're doing your suturing and things like that which isn't very pleasant, but most of the time it doesn't make much difference 'cause you're used to them being there."*Dr3. They thought that the father was there to give the woman support, encouragement and to help her with *"pushing and things like that"* and be *"someone to shout at"*dr3. Another agreed with this and although she considered *"it varies"* she thought that they mainly wanted the partner there *"for support and encouragement"* dr2. Whether or not the man could actually give support was questioned and one doctor considered that it depended on the *"relationship between the couple"*dr1

They considered the presence of the father to be mainly beneficial for the woman except *"occasionally the fathers can seem to wind up the mothers."* dr3. They all thought that the fathers should attend antenatal classes so they could have a *"bit of information about what to expect and what labour's about rather than going into it blind"* dr2. Also they needed to understand about the pain because *"sometimes that's quite upsetting for them so maybe there should be more emphasis on that, and it can be quite distressing to watch them be in so much pain."* dr3. Another point of view is that by going to the antenatal classes fathers would have a greater involvement in the whole affair.

"I would say it depends on how educated the couple are. You could probably draw a line between the more intervention the father has in the labour, in general the more intelligent they are. The best way would be to regard it as a joint experience as opposed to just for the wife, which is generally what happens. Basically I'm suggesting they should get the husband more involved in the whole thing. Starting from scratch, antenatal clinics, the whole works. It seems as though the husbands are just dragged along." Dr1

Overall the presence of fathers in the labour room was something that doctors were used to. They did not see them as being relevant to the care they gave the woman except in a peripheral way. They could be useful at

times but in general they were there for the woman to support, calm and encourage her so the doctor could get on with his or her work. This coincides with the doctors' view that they are there to do something to the mother when her labour deviates from normal in order to produce a positive outcome i.e. a healthy mother and baby.

Midwives' Beliefs about Fathers in the Labour Ward

The midwives like the doctors thought that the presence of the father in the labour room made no difference to the length of the woman's labour, the amount of pain she experienced and the care that the midwife gave to the woman. However unlike the doctors they talked at length about the role of the father and his perceived effectiveness or otherwise in that role.

Effective or Competent?

The father was considered to be there to support the woman and to be there for her. However according to one midwife they are *"so scared and they think they are in our way that they tend to sit over in the corner about ten feet away from their wife or girlfriend or whatever."*^{mw3}. This belief was shared and according to another midwife who although she thought that *"in some cases the man takes a real active role and is very supportive, gets very involved and tries to join in"*^{mw2}. Some men were considered to be terrified of the experience particularly if they were young and frightened of the experience and of the hospital setting and so may be *"neither use nor ornament" ...and sometimes quite domineering and abusive*^{mw2} to their partner. Other midwives echoed the belief that the men were not very useful on the whole. One considered that mothers and sisters of the woman were more helpful and supportive because they have a more experiential knowledge than the male partners. *"I would say the majority of the time the mothers and sisters will give them more support and the right kind of support"*^{mw1}. They know how to help the woman *"through it"*^{mw1}. She thinks this is particularly the case where the woman is a *"young girl"*^{mw1} and has not known her boyfriend very long. *"The mothers seems to, she has been through it and she knows, she understands what is going*

on. *The younger girls who haven't been with their partner for long get more support from their mothers"* *mw1*. This midwife thinks that the role of the supporter is to encourage the woman especially when the going gets tough and to reassure her that it is all right. She said the woman's *"mother will be the more supportive one there and help more and explain what is going on so they can understand it"* *mw1*. She thinks it is important to be surrounded in labour by women because they have a female to female relationship. Men, she considers, are sometimes ineffective in their help and need to be told what to do whereas it comes more naturally to women. *"You are telling him all the time whilst often the mother will often just wipe her face and cool them down and make them more comfortable themselves"* *mw1*. In her opinion female knowledge leads to an understanding of the woman in labour.

The preceding comments showed that the midwives related effectiveness to doing something for the woman in labour. If one considers this as a performance indicator then it can be tracked back to the category of competence. The learning outcomes for the midwifery educational programmes are outlined in Rule 33 of the Midwives Rules (U.K.C.C. 1998) and list a set of criteria which have to be met for eligibility to register with the U.K.C.C. as a midwife. These are more commonly known as the competencies. Overall the two categories into which a midwife must demonstrably fit are those of competent and safe. As midwifery as yet does not have its own specialised body of knowledge and sits uneasily between obstetrics and lay, common-sense behaviour in the care of a woman having a 'normal' life experience it is not surprising that midwives guard their right to care very jealously. They considered that the men were not effective but gave no indication of the measures they were using to gauge the men's competence. This clashed with the results of the questionnaires (appendix nine).

Support or Supporter

The midwives showed the contradictions in their thinking in that although they did not think that the men were effective they did think that they should be present. (It is possible that this arose from their belief system as midwives as against their personal experience as women). One midwife tried to clarify her thoughts by saying that she thought the men were there to support the women and when asked what this meant she replied, *"I don't know. To hold their hand. Whatever the wife wants them to. Just to do what they want them to do. To hold their hand or rub their back"*. *mw3*. She then went on to say the main role of the man is to *"reassure them really that they are not on their own, because I think being on your own is the worst thing. You can be surrounded by people all in their uniform who are doing sort of them medical or clinical bit"* *mw3*. She thought that they could, *"distract them. I do think there is a place for them. I do think they benefit from being there."* *mw3*. She thought that the man could distract his partner and talk to the midwife. *"Some are good at keeping things going, chatting and talking to you and some are so scared they don't know what to say. They sit and watch the monitor and if you try to talk to them, it's yes, no."* *mw3*. Another midwife considered that the man was there to alleviate the loneliness and to validate the woman's experiences. He was there to, *"sit with her and be with her as a couple so he can see. He can perhaps see what she has been through and when she is relating it she can say 'Oh do you remember this happened and that happened. So she has someone there.'" mw1*. Another midwife thought that just *"having someone they love and trust helps to calm their fear"* *mw2*. She expanded on this by saying that it helped the women to know that *"someone they love and trust is there to keep an eye on things"* *mw2*. This theme of being together was repeated by another midwife who saw the role of the partner as being there to sit with the woman, validate and share her experience, her special moment. It is their baby and so following the birth it is their time to be together. *"That is their baby for them to be with and I am a little*

bystander at this time. It is not my time to be with them or to tell them anything." Mw1.

The father could now be legitimately in the labour ward as a supporter where the concept of support was considered to be social and loving with its own set of rules of behaviour as distinct from psychological and physical support which can be identified as a professional role. By embracing the first meaning, the performance indicators are entirely within the private domain and personal philosophy of the couple, and the man's success or not, depends entirely on their individual expectations. This is supported by some of the beliefs of the mothers and fathers as discussed in earlier chapters. This understanding of support does not conflict with the role of the midwife. The midwife can now still be the expert and provide care which indicates the concept of support as being that given by someone with professional knowledge based on psychology, biology and physics etc. So the midwife's support will be twofold in that she will be monitoring the woman as a person of mind/body (the biomedical) and a more formal aspect of the social i.e. control. The father can now be fitted into the hierarchy of labour ward without being a threat to the midwife's professional competence as is seen in the discussion of their standards.

Standards of Care

The midwives considered that they were the chief carers and had the power to grant entrance to the labour ward although as one midwife said, *"I would never refuse anyone access into the labour ward unless they were causing the mum to be upset and she expressed a preference that they weren't there"*.mw2. They were all adamant that the presence of the fathers had no effect on the type and standards of care they gave. A typical comment was,

"My own standards of care doesn't change regardless if the father is there or not. It helps but it is not just the father being there. It is if another person is present. I think it helps the midwife if she leaves the woman to see to another woman

*because there is another adult there. Sort of, you know, four eyes are better than two, you know that sort of thing but it doesn't have to be the partner, a male figure."*mw2

Another midwife although she initially said that the presence of the father had no effect on her care she later corrected herself by saying that she had to *"make sure that he knows what is going on when you are explaining things but other than remembering that there is another person there for you to, look after I don't think it affects the care of the woman"*mw3. The midwives considered that they had the professional knowledge to be in control and make the woman feel safer, (*"the majority of the time they feel safer and more supported with the midwife around"*mw1.) and to relieve her pain. The fathers could not help with pain relief because *"basically if the woman is distressed with pain they really don't know what to do and they hand back control"*mw1. . They related this ability to being a midwife rather than being a female because all of them considered that male midwives gave equally good care and showed empathy and problem solving skills. However one midwife had reservations about the presence of a lot of male doctors in the labour ward,

*"I think when women find they are surrounded by them it is quite threatening for them. I mean particularly, or hopefully it doesn't happen here, when, but particularly we have a ward round and there can be seven or eight of them.....I don't think a woman should be in labour or what have you and be surrounded by all these men, looking at her and discussing her. This doesn't happen here and if it did I would be very upset."*mw1.

Yet another midwife qualified the presence of males by saying that the women *"associate male doctors with big hands"*mw3 and find examinations by them uncomfortable.

Delivered Knowledge

Parentcraft education for the father was believed to be a good thing by all the midwives for three main reasons. The first was so that the father can *"have it explained to him what she is going to go through and to know*

certain things like, you know you bring this in for her and."mw1. The second is that they will "feel part of the pregnancy, part of the actual process that they have started as a unit from day one and they come into the labour ward as a unit."mw2. The final reason given was so that the father would have enough information not to be either too shocked or too complacent in the case of an emergency caesarean section. They would also not take up too much of the midwife's time in explanations because "you haven't got five minutes to sit down with them and say well this is...."mw2. All three of these reasons point to the belief system of the midwife. The knowledge that the father can acquire through parentcraft education, is information and explanations delivered to him by the midwife. These are intended to make his role as a supporter of the woman easier, to equip him to deal with minor practical issues and to make him less of a interruption in the smooth flow of labour ward events. None of it is intended to equip the man to challenge the midwife's authority in the labour ward.

Conclusion

On examining the beliefs of the midwives and the doctors as revealed in the interviews it could be seen that the doctors were relatively straightforward. Their beliefs were (unsurprisingly) congruent with the biomedical model in that they considered their role to be part of the intervention process when labour when it had veered from the course of normality as outlined in the management of labour protocols within the labour ward setting. Their very presence in the labour ward depends as Davies-Floyd points out on the metaphor of the female body as an 'abnormal (deviating from the male norm) unpredictable and inherently defective machine.' (Davies-Floyd 1992). They were 'fixers' ready to swing into action with Ventouse extraction, forceps or caesarean section when things went wrong.

The midwives were in a more ambivalent position and this was clear from their responses. It was clear that they had taken on board several of the features of the biomedical model. The underlying metaphor seems to have been modified to consider the woman's body to be a potentially rather than actually dysfunctional machine. Rather than acting as 'fixers' they were 'monitors', 'saviours' and 'deliverers'. They monitored the physiology of labour for normality and saved the woman from the intervention of doctors when they could and delivered the babies. Their terminology was always midwife-centred rather than woman-centred for example they 'did a delivery' rather than 'helped the woman to give birth'. They considered that they were in control of these functions. The father was considered to be inferior in any of these practices and in all the active aspects of care he was considered to be inept and ineffective. This was necessary in view of the precarious position of midwifery if it wants to be considered a profession rather than skilled work.

On the other hand they seemed to believe in the concept of woman-centred care and recognized the father to be a source of support for his partner. They understood that his presence was needed by the woman and were careful to give him some *raison d'être* in the labour ward as long as it did not conflict and was subservient to their own role and status. In this they were true to the ambiguities inherent in the midwifery models which rely on views of women as social beings rather than a worldview of the woman's body. The difficulty with a care model which relies on the assumption of a woman as the centre of care with the right to make choices and have control over her own body is that it does not take into account the role of women in society. It especially does not consider the status of women in an institution, which has power and control, derived from the State and directed on a biomedical model, as will be discussed in a later chapter. Neither does it consider the status of the woman in labour in an institution where the challenge to doctors is from a male dominated managerial structure and midwives are not major

players. A woman in this situation needs authority and it remains to be seen whether or not the father can actually help her to be so empowered.

Chapter Five. Another perspective - Opinions

Introduction

Quantitative questionnaires were developed from the foreshadowed issues that came out of the literature and from the data generated by the semi structured interviews that I conducted prior to entering the labour ward. In this chapter I consider information from these questionnaires. All the information presented in this chapter comes from the multiple choice questions following their analysis using S.P.S.S. and from the qualitative information given as comments at the end of the questionnaires. I examine, present and draw conclusions from the data in terms of the opinions and the expressed meanings of the participants. These were expectant fathers, pregnant women, new fathers, new mothers, and midwives and doctors. The chapter is structured around the six sections of the questionnaire i.e. the personal information, the presence of the father during labour and at the birth, the role of the father, the context, education for labour and birth and gender issues. The information is presented qualitatively whilst the results are presented in numerical form in appendix nine.

Participants

The questionnaire was sent out to 570 people (100 each of expectant mothers, expectant fathers, newly delivered mothers and fathers, 50 midwives and 20

| TABLE 5.1 NUMBER IN SAMPLE | |
|----------------------------|------------|
| <i>Expectant Father</i> | 39 (16.8%) |
| <i>Expectant Mother</i> | 38 (16.4%) |
| <i>New Father</i> | 58 (25.0%) |
| <i>New Mother</i> | 57 (24.6%) |
| <i>Midwife</i> | 34 (14.7%) |
| <i>Doctor</i> | 6 (2.6%) |
| <i>Total</i> | 232(100%) |

doctors). A total of 232 questionnaires were returned giving an overall response rate of 49%

The mean age of the population was 29.2 years with the midwives being substantially older (40.6 sd 1.3) which was reflected in the overall sd of 1.0 (See table 5.2)

| TABLE 5.2 AGE OF THE POPULATION | |
|---------------------------------|-------------------|
| <i>Expectant mothers</i> | 26.7 (sd 1.5) |
| <i>New fathers</i> | 28.7 (sd 1.2) |
| <i>New mothers</i> | 30.1 (sd 1.3) |
| <i>Midwives</i> | 40.6 (sd 1.3) |
| <i>Doctors</i> | 32.6 (sd 1.2) |
| <i>Mean</i> | 29.2 (sd 1.0) |

The majority of the men and women were either expecting their first baby or were first time parents. The next largest group were second time parents. Only 8 health professionals answered the question about parenthood so it was impossible to say whether or not the others had children.

| TABLE 5.3 PARENTHOOD STATUS OF THE POPULATION | |
|---|----------------|
| <i>1st time parent</i> | 124 (53.4%) |
| <i>2nd time parent</i> | 44 (19 %) |
| <i>3rd time parent</i> | 19 (8.2%) |
| <i>4th time parent</i> | 3 1.3%) |
| <i>5th time or more</i> | 1 (0.1%) |
| <i>Not answered</i> | 41 (17.7%) |
| <i>Total</i> | 232 (100%) |

The Presence of the Father

There was a consistency of agreement between all the groups that the father should be present at the labour and birth regardless of any obstetric complications. This supported the assertion that the father's

presence is moving towards a social norm and one new father actually said that he thought, *“it is now the social norm and that family/friends etc expect you to be present”*. Everyone, except the new mothers who thought they always wanted to be there, was in agreement that the men frequently wanted to be with their partners in labour. The biggest significant difference was between the midwives and the new mothers. Only three people elaborated on this, a doctor, an expectant father and a pregnant woman

The doctor wrote,

“I think (based on anecdote) that most men would only like to be on the labour ward intermittently i.e. not throughout a long labour. The best support for a labouring woman is either her mother or any other close female friend”.

Male doctor_{q222}

The first expectant father spoke about the importance of the birth to the relationship.

“The labour and birth of a child is very important to both partners. That is why it is important to the father of the child (that he) should be there no matter what the circumstances”.

_{q100}

A pregnant woman put a slightly different slant on this when she said that,

“Fathers should always be at the labour and delivery of their child to show they care for their other partner who is in labour, because the partner (father) of the child is also playing a part”.

_{q71}

There had been no significant differences between the groups in relation to pressure that men were under to be present at the labour and the birth. They all agreed that the men were rarely under pressure from the

staff, occasionally from other men and frequently from their partners. An expectant father described the pressure.

"My wife has been getting at me because I have not seen any of my two babies born. I was working with the first then the second baby I had to wait outside. I felt ill". q108

One wonders if it was his wife, who implies that this might be due to a lack of knowledge that could be resolved by education,

"My husband is very good but when I went into labour with my second baby he went outside. I think that fathers should be told a lot more, even shown videos and given books on birth". q86

It is possible that childbirth throws up all sorts of conflicting feelings as is evident in the mixed observations of this expectant father

"I believe that fathers should have the option of being present at the birth (I intend to be there myself) but I don't think there should be any element of compulsion however subtle or slight. I am sure many men feel obliged to be present irrespective of whether they want to be or not. I am not convinced that the presence of fathers during childbirth is necessarily appropriate or desirable." q103

One can only speculate as to why he wants to be present if he isn't under any compulsion and considers it might not necessarily be appropriate or desirable. Only one person (a new father) spoke about the desires of the woman and he said, that he knew some woman who *"I know have stated that they would absolutely not want their husbands present. I think what is important here is informed choice for all. q62"* Only one midwife gave an insight into her opinions (and prejudices) when she said,

"Some birth partners are fantastic support whether they be fathers, mothers, or friends. Some – you would wonder why they are here at all. Many seem to just want to watch and see

the birth. I've seen men with their backs to their partners. Many are far more interested in watching television, sleeping, smoking etc. than supporting their partners. Don't like to seem a snob but I would say generally that the higher the social class and the older the father, the more support he is likely to be. (OK! I'm a snob!)"

Midwife_{q208}

It can be seen from the above results and comments that although the men may have felt under some pressure to attend the labour and birth it was in the main personal rather than social. This supported the idea (as discussed in the previous chapter) of cultural drift. As yet the presence, rights, duties and authority of the father in the labour ward is still open to negotiation and so it is not yet a social norm.

The groups all considered that the care given by the doctors or midwives was only occasionally affected by the presence of the father. There were no explanations given as to what these were. In the case of the doctors who were adhering to the biomedical model and objectifying the women's bodies, it would make sense that their care was unaffected by the presence of third parties. It also links in with their beliefs as discussed in the previous chapter that they considered the presence of fathers to be beneficial to the women. Also the fact that they were used to the men's presence in order to give the women support and encouragement. It was also not surprising that the midwives views were closer to those of the expectant fathers because it likely that they were congruent with the beliefs previously expressed that effectiveness meant doing something. The midwives may believe as did the midwives in the previous chapter that the men were not very useful in this respect, and the expectant fathers may believe that they know too little to be useful. The remarks did not clarify this particular issue as they were mainly from new mothers and new fathers and were full of praise for the staff." Typical comments were

"These are some of the most dedicated and friendly people I have ever seen

New father q171

"I thought the staff on the labour ward were very encouraging and the anaesthetist was calming and confident too. The doctor was also involved with my birth and she was excellent. All staff communicated with each other and all the signs of complications were very well anticipated.

New mother q157

"They gave me confidence and a positive attitude throughout the delivery and the stay. They gained my trust and respect immediately."

New mother q155

"Brilliant experience! Brilliant staff! Brilliant hospital! Brilliant hospitality!"

New mother q152

In my experience I found the care we have received to be excellent.

Expectant father q87

There were only two notes of criticism and they were implied rather than voiced. For example in the caution,

"I think doctors and midwives should genuinely listen and act more quickly on partners'/mothers' intuition and questions, concerns rather adhering to protocol thus blinkering their judgement. It may be a 'matter of fact attitude' because the staff deals with birth every day in day out – but they should never forget the great importance it is to the couple".

New father q54

and in the instruction that,

"More attention should be paid to the birth plan of mother and tried to be followed as much as possible. A definite action plan should be discussed and reviewed at every stage of labour,

and timing of when pain relief can and cannot be given (or when it will be too late to be given) should be made very clear.

New mother q159

Doctors and midwives made no comment on the care that they gave.

The Role of the Father

There was a consensus of agreement on a number of issues related to the role of the father. They thought it was important to give encouragement to the woman, help reinforce breathing exercises and to act as an advocate.

They all thought it was very important to make the woman feel safe, validate her experience and have shared memories (although there was a wide spread of opinion on this matter (mean 4.569, sd 3.512). It may be that they thought these factors were so self-evident and unthreatening to the status quo that no one made any comment on them. The puzzling exception to this is perhaps the role of advocate which could be seen to be troublesome, unless of course in reality it is only a theoretical construct or is considered to be more of a interpretative function as did this woman,

All staff communicated with my husband and it was vital to relay and reinforce information to him so I could gain any information from him in order to complete the whole experience and understand why things were done later on when you are more aware.

New mother q157

There was a significant difference between the midwives and the new fathers on several matters. In regard to whether or not the father should help relieve pain the new fathers thought it was important but the midwives thought it was only sometimes important. A midwife thought, *"fathers could take a more active role with our help - for the benefit of their partner. q173"* The only comment apart from this was from a new father

who was obviously upset when spoke about his feelings and powerlessness when the doctor was not available to give pain relief,

"Personally there is only one that got to me was when my girlfriend was around seven centimetres dilated she asked for a mobile epidural, but when the midwife came back she said the anaesthetist was busy in other parts of the hospital. But when he became available it was too late for her to have the injection. She had to go all through the pain without any real pain relief."

New father q52

As a midwife I wonder whether this was the real reason that she was not given an epidural. A first time mother could possibly have had at least three to four hours before delivery was imminent, which would surely be enough time for the anaesthetist to become available. If she was experiencing her second or subsequent birth it could have been much shorter and the midwife may have thought birth was imminent. One can only conjecture as to what the circumstances were.

Midwives differed from new fathers on the issue of whether or not the father should help the midwife. Midwives thought it was rarely important whilst the new fathers thought it was sometimes important. This view was echoed in the responses to the question of whether the father helped the doctor. The midwives disagreed with the new fathers and again thought it was rarely important whilst the new fathers thought it was sometimes important. This might be because the men were in fact as Summersgill (1993) asserts being given 'pretend' roles. If it was the case it would explain the difference in perceptions. Only one person (a new mother not a midwife or new father) made any remark that could have alluded to the men's helping role,

"As my husband is in the ambulance service and has delivered babies in the context of his job I felt very secure knowing he was there helping throughout the labour and delivery".

New mother q153

Midwives also disagreed with the new fathers and with the pregnant women in regard to the importance of the father's role in watchfulness on behalf of the mother. The midwives thought it was sometimes important whilst the others thought it was important. This fits with the idea of birth as dangerous and the ascribed gender roles where the woman is passive and the man alert and watchful in the presence of danger. Nobody had any direct comments on this.

New fathers and new mothers disagreed that one aspect of the father's role was to be the focus of the woman's anger. The new mothers thought it was only sometimes important whilst overall the new fathers thought it was an important factor. However the large standard deviation showed that there was a wide spread of opinion on this matter and nobody made any written comments on it. Interestingly the other question that showed significant variations was that of whether or not the father should distract the woman. Expectant fathers thought it was important for them to do so but the new mothers did not agree and thought it was only sometimes important. This might be because as Odent (1984) pointed out the woman in labour is not inactive, nor is she suffering a superficial, irritating pain that she can be distracted from. She is very busy in that she is experiencing and managing her labour and birth herself in her own way. As labour progresses her attention becomes more and more focussed on the contractions and any distractions may only serve to make her lose concentration and focus.

When asked whether the father was usually an effective supporter or not the expectant fathers showed that although they thought they would probably would be, they were significantly less confident than were the expectant mothers, new mothers or the new fathers. They all thought that they would always definitely be effective. The expectant fathers were in agreement with the midwives who significantly disagreed with all the others in that they too thought that the fathers would frequently but not

always be effective. This correlates with the comments (previous chapter) that showed that midwives related effectiveness to their competencies and the doing of something to or for the woman in labour. It is a subjective opinion based on the person's own definition of effective and this might mean doing nothing as one new mothers said, *"My partner attended all through the labour but I didn't want him to do anything. Just being there was enough"* q129. This was echoed by another woman who found, *"my husband thought he was of little use but he was great!"* q128 and yet another who said, *"The father's role is very important and I personally could not have got through it without my husband being there."* q157. However the Despite this there were several comments about the feelings of helplessness in the role. These are exemplified by,

"I found that my partner could not handle the labour and birth but his actual hands on experience was of no use as I think the whole experience was such a shock to him."

New mother q143

"In general I feel that expectant fathers feel completely useless during labour and birth."

Expectant father q104

The Context

There was general agreement that the institution had not provided comfortable seating for the fathers in the labour ward and some disagreement on the remaining questions. The midwives thought there was inadequate provision for men to stay overnight in contrast to the new mothers and new fathers who considered it quite good, and the expectant fathers and expectant mothers who thought that it was good. This difference of opinion was reflected in the knowledge about the men's ability to obtain tea or coffee except, that new fathers agreed with the midwives that the provision was inadequate. Expectant mothers showed

a significant disagreement with new fathers regarding the toilet facilities for men. The women thought it was good whilst the men thought it was only quite good. The midwives once again disagreed with the others about the quality of shower provision for men. They thought there was no provision in contrast to expectant fathers who thought it was quite good and new fathers who considered it inadequate. Expectant mothers contrasted significantly with new fathers and new mothers in that they thought there were excellent facilities. It is possible that the expectant fathers and expectant mothers had perhaps been on a tour of the unit and thought that the showers they had seen were available to the men to use. It is also possible that the new mothers misunderstood the question and were talking about the provision for them because in reality the midwives were right and there was no authorised provision for men. This may have become obvious to one new father, who provides his 'wish list' as follows,

- *Toilet/shower washroom*
- *A chair bed*
- *Music mood etc. videos*
- *Tea/coffee facilities*
- *Fridge*
- *Sink/drain*
- *Associated reading material*

New father 96

This aspect of the questionnaire focussed on the resources and facilities of the institution rather than the restrictions. It was perhaps not surprising that the midwives who had identified quite strongly the lack of these did not give any suggestions about utilising the existing facilities such as toilets and showers.

The doctors and midwives were in agreement that the reasons behind unhelpfulness by the father were associated with lack of maturity and knowledge about labour and birth, an unpleasant character, and an unstable relationship. They were all in agreement that they had never

experienced physical abuse to midwives, doctors or women and whilst they had occasionally experienced verbal abuse to both midwives and doctors they had rarely witnessed it to the women. Even so a doctor felt able to explain it as,

“Being secondary to partner who has been drinking prior to attending the labour ward. Restriction of other accompanying parties would help. Often father leaves room to progress report to hordes in waiting room who then tell him things aren’t going well etc.”

Female doctor q66

It is interesting to find that there was such little personal experience of verbal and physical abuse and yet the policies restricting visitors seemed to be based on the assumption that the presence of fathers would bring a degree of violence to the labour ward. It is a catch twenty two situation in that it is possible that men are really violent and the policies are successful in curbing this or the restrictions are in effect for another purpose because men pose no threat of abuse. The only way to resolve the question would be to lift restrictions and monitor the process.

All the groups were unanimous in thinking that the labour ward was a place where the fathers would feel apprehensive and this was echoed in the following comment,

“It is supposed to be the most memorable thing you see in your life, but then there is difficulties at the birth itself which was the case in our situation. It was very frightening. In saying that, I was glad I was there for my partner.”

New father q1

Education for Labour and Birth

All the groups thought that antenatal classes were held at a suitable times, on suitable sites and that men frequently attended them. However one new father pointed out that the,

"Timing of the antenatal classes (2pm) was inconvenient for me as it coincided with the start and end of shifts on alternate weeks meaning it was difficult for me to attend on either shift."

New father_{q4}.

Three other men agreed with this comment and one considered that employers should allow time off for the father *"just as much for the mothers i.e. parentcraft classes, midwife appointments and time off, for time to be with his baby!"*_{q100}. He was voicing the need to be included that had come up in the interviews. It was his baby and he did not want to be excluded.

Although antenatal classes are seen as a venue for obtaining knowledge there seems to be at least one person who thought that they were not publicised enough. He also seemed so overwhelmed by the process of events in that he needed somebody keep him and his partner informed,

"It is not enough to expect people to 'just know' that the classes exist. New parents to be (especially first timers like ourselves) have got enough to worry about. Their minds are full of the things they need to remember for going into hospital. They don't need to remember things they know nothing about. I think you would be surprised at the amount of people who feel the same way."

New father_{q171}

The antenatal class information was the officially sanctioned knowledge and unsurprisingly the midwives and doctors thought that when men had attended classes they appeared more informed in the labour ward. New mothers considered the content to be an excellent preparation but expectant fathers and midwives were less convinced.

Expectant fathers thought the content generally good. Previously expectant fathers had told me that apart from dilation etc. they did not need to know *"medical things"*_{ef1}. They had a dread or fear that they could not conceptualise and it is perhaps this aspect of the process that antenatal classes do not address. Midwives rated them as having only

adequate content. Initially I found this surprising but on reflection consider that it might be due to blockages in the internal systems of communication i.e. There might be little feedback from the post natal and labour ward midwives to the midwives who are providing the classes. Comments about the content were varied,

"I feel it would be helpful to first time parents to be given a form of 'timetable' of likely events once labour commences. I understand that time scales can vary significantly but if there was a set of 'milestones' identified for each phase of labour it would ease worries significantly."

Expectant father q103

"More explanations of actual birth situations, plus what they are and how the machines work that are used."

Expectant father q93

Gender Issues

There were no significant differences between groups regarding whether the midwife or doctor was a parent themselves or what their gender was. They thought that parenthood had only a slightly positive effect on the credibility of the midwife or doctor's practice and the carer's gender was irrelevant. For the people who had thought it relevant then they wanted the midwife to be a woman. The question regarding the gender of the doctor was not answered in these cases. Two midwives commented on this. One said, *"Usually gender is important in some mothers' cultures i.e. Somali mothers prefer female attendants."* q207.

This was an assumption and as Currer points out (Currer & Stacey 1991) there is a wide variety of beliefs within a culture. For example even among Pathan women who she considers to be the most secluded of Muslim women 'purdah' can be accepted to a greater or lesser degree. The other midwife whilst supporting the first midwife's statement also made a reference to the rights of non-religious/ethnic women to have an attendant of choice as part of the individualised care process,

"I personally think it is irrelevant whether doctors or midwives are male or female however I appreciate that some women may

prefer a woman carer especially certain religious groups. I personally feel it is irrelevant whether a midwife had undergone the birth process herself, as birth experiences can be both positive and negative.

Midwife q209

When asked about the presence of the woman's mother or a female friend the midwives answered significantly differently from the other groups. They rated the grandmother as slightly more helpful than the father. This was in keeping with the views expressed by one of the midwives in the preceding chapter who linked the grand mothers' help with experiential female knowledge.

This contrasted with the new mothers and new fathers who thought there would be no difference and the expectant fathers and expectant mothers who considered that the grandmother would be slightly less helpful than would the father. The only comment was by a new mother, who said,

"I think it was helpful for me to have my sister and my husband present as I needed my husband's support, but my sister was able to relate to the situation more and give me advice as had been through this three times herself.

New mother q156

There was a difference of opinion between the groups when asked did they think the presence of men in general on the labour ward would be embarrassing to the women. The midwives, new mothers and new father thought that women would rarely be embarrassed whilst the expectant mothers considered they might occasionally but the expectant fathers thought they would frequently be so. Expectant fathers and midwives rated the presence of men in general as slightly more threatening than did the new fathers, new mothers and expectant mothers who thought they would never feel threatened. There were no comments on this aspect. Nevertheless this fits with the previously discussed perceptions of expectant fathers where they see themselves as watchful males guarding their mates from danger, and in particular that from other males.

Conclusion

In this chapter I have taken the concepts and issues from that became evident from the literature and the semi-structured interviews, and then built them into a quantitative questionnaire. By sending them out to a larger sample of participants I was able to consider whether or not the group that I had interviewed were typical or not in their views. Overall I found that the questionnaire data supported the interview data.

There were significant differences in opinion at times between the groups. The aspect where the most consistent differences appear is that of the role of the father in labour. The midwives tended to disagree with the other groups although there is some disagreement between the others. Not surprisingly the expectant fathers and mothers often had a different perspective from the new fathers and mothers. There was agreement that the fathers were important to give encouragement, help her through the experience reinforce breathing exercises, make her feel safe, validate her experience, have shared memories and act as an advocate. This did not conflict with the midwives' belief that their role was to give professional support which involved doing something for or to the woman. whilst the father's role was more social in character. No new issues or concepts were brought to the fore and the data supported the previous assertion that although men are present they are in an institution that does not cater for them and seems to suffer their presence. Women were definite in that they want their partner to be present, but whether this was for protection, advocacy or support or all three was not actually clear. As the men's presence was generally seen as neither useful nor problematic by the midwives or doctors it remains to be seen how they can deal with the power regulations and also meet their own and their partners' needs in an institutional setting.

Chapter Six. Power, Compliance and Alliance

Introduction

In this chapter I look at the way decision-making in the labour ward is conducted through the interaction of power structures. I am concerned from the more recent Foucauldian perspective with the way the institution acts as a technology of the 'Gaze' and how power relationships are formed. The main object of the 'Gaze' is the fetus, which has been subjected to rigorous quality control checks throughout its short life. When it is in the crucial transition stage of birth and is moving from the uterus of the woman (nature) into the 'culture' of the world it is considered to require constant observation. It could be argued that in order for this to be successful the woman should be made as submissive and inactive as possible. The chapter looks at the way the powers of the State are interpreted and transmitted by the doctors and the midwives through a series of hierarchical relationships. These relationships act in turn to observe and control the woman and the fetus on behalf of the clinical institution and by extension the State. The structure, the mechanisms and the use of artefacts bring changes in performance and result in a certain type of work management. To make this easier protocols, rules, social norms are brought into play. These may also have the effect of making the woman and her partner compliant and passive. Most of the inherent power structures work on the father as well as the mother.

Power

It is clear that decisions are made in the labour ward and labour rooms and actions taken on the basis of these decisions. To understand how these come about and the limitations that are brought to bear on them it will be useful to look at Foucault's conceptions of power.

In the preface I introduced the idea of the State's power and how in a democracy it is seen to be a legitimate authority. It may seem that the

State has a totalizing political power that is wielded by its agents for the good of the whole and in doing so ignores and controls the individual. Disagreement would result in resistance and struggles against domination. However, according to Foucault (1983), this is an older more archaic form of monarchical power. The success of the Modern State lies in the fact that it has unique ways of functioning. One such way is through what he terms bio-power which although apparently benevolent is both *'individualising and totalizing'* and functions as a particularly wide spread and effective form of social control. It works by assuring the individual of worldly salvation through improvements in health, standards of living, security and protection against accidents. There is no one power resting on high but rather a series of powers coming from below within which everyone is enmeshed. There is a synthesis of a *'series of powers: those of the family, medicine, psychiatry, education and employers'* (Foucault 1983).

These powers are not usually exercised to modify, use or destroy a passive and fatalistic individual but rather they form the basis of a set of inter-relating power relationships. These are of broadly two kinds, disciplinary and regulatory. Disciplinary powers are effected through knowledge of and power over the individual body treated as a machine and are located in institutions such as hospitals and schools. These powers lead to a docile, useful and productive body. There are also regulatory powers over the "species body" (Sawacki 1991), i.e. the body that serves as the basis of biological processes e.g. birth and death. According to Foucault (Dreyfus & Rabinow 1983 p113) this body is the object of interventions and is studied through demographic and public health agencies. Power does not actually lie with the hospitals and other institutions as such. They are but the means of articulation of the political technologies and mechanisms in which time and space are used as micro-powers to organise and discipline individuals as fixed and docile bodies (Foucault 1991 p143). These interface with strategies that aim to

make the individual believe in knowledge as external to power, and self disclosure as therapy. The effect of this way is that the individual comes to consider interventions as necessary and therapeutic, and he or she becomes a willing and subjective accomplice as well as a disciplined, objective body.

In the power relationship there is no constant equilibrium and there is no function of permanent consent. *It is not a general system of domination exerted by one group over another, a system whose effects, through successive derivations, pervade the social body* (Jones 2001 analysis of Foucault 1980). Power is exercised through the use of space, controlling regulations, and communication systems such as signs of obedience, orders, hierarchical symbols and dominant knowledge with people ranked accordingly. According to Foucault (Dreyfus & Rabinow 1983) the relations are put into place by means of *“a series of power processes (enclosure, surveillance, reward, punishment, the pyramidal hierarchy)”* that both discipline the individual and encourage compliance and self-discipline. A power relationship does not act upon people directly but is a *“total structure of actions brought to bear upon possible actions”* (Dreyfus & Rabinow 1983 p209). It is not acquired or seized, and it cannot be held on to. Rather it is capillary, circulatory (Kruks 1999) multifaceted and exercised at many points.

Inherent in the power relationship are struggles and insubordinations that are only stabilized when one of the parties has reached its limits of power, is rendered impotent for the time being, and ceases to struggle. However the most crucial aspect of this type of power relationship is that it is not enforced too violently (with the risk of revolt), nor is there too much intervention (with a risk of disobedience). Instead it seeks to normalise the social situation and,

“In this way the modern subject becomes inextricably linked to the society of which they are a part through turning themselves into an object. Body, time and space are strictly controlled

Foucault in Dreyfus & Rabinow (1983)

What this means in effect is that probably all institutional relationships are those of power, which is immanent rather than external. The person thoroughly internalises the rules and regulations and is constrained by the technology of individuation. In other words one is not only the object of the gaze but becomes the subject who gazes at him or herself. He or she actively uses the power of the institution against him or herself and at others. Just as the organisation brings a structure of actions to neutralize the individual's possible behaviour, the person acts as a monitor and disciplines himself accordingly. Although, according to Kruks (1999), Foucault does not clarify just why and how the panoptic gaze induces such an active compliance she draws upon Beauvoir's (1947) account of becoming a woman and in particular learning 'shame' under the male gaze as a factor in complicity. Also according to Beauvoir (Kruks 1999) women are particularly complicit in sustaining these normalizing practices as *"compliance is a rational strategy for many women"* (Kruks 1999 p 7). For example *"for a dependent or low earning housewife, the economic costs of a that might result from resistant behaviour can be catastrophic"* (Kruks 1999 p16) and so compliance may be *"an interest maximising agent"*. In the labour ward a woman and her partner may seem to be compliant for such a reason, e.g. a belief in maximising safety for the baby

The 'Gaze' and Power Structures at Local Level.

The Structure and Design of the Labour Ward

The labour ward is, as was briefly described in the context chapter, a modified panopticon design. Bentham's panopticon model as Foucault (1991) points out is excellent for regulating and controlling behaviour in a disciplined and disciplinary society. He maintains that all the authorities exercising discipline function according to a binary mode whereby individuals are branded "mad/sane, dangerous/harmless, abnormal/normal" (Foucault 1991, p199). A set of techniques is devised for monitoring, measuring, supervising and correcting. An overall binary

system is at work in that the individual is either included or excluded. The major effect of the panopticon is to ensure that the individual is consciously and permanently observed. This enables the power relation to be exerted automatically through the architecture, through the procedures and through the people (including the observed). In the perfect panopticon the gazed upon are kept in single rooms or cells built in a circular arrangement around a central point from which the gazer can view each individual. The individuals cannot see each other nor can they see the gazer and so they behave as if they are watched all the time. The labour ward followed this design fairly closely in that the midwives and the doctors were the gazers and the women and by extension the fetuses were the gazed upon. The labour rooms were used to house an individual and there was neither contact between individual women nor between individual women and midwives other than those designated as their carers. Once in the room the women were not encouraged to leave. The exception to this was if a woman was in very early labour she could go to the shop or dining room accompanied by her partner but to do this she had to receive permission from the midwife. Like her partner she was only allowed to walk through the labour ward and past the midwives' station. Stopping was not encouraged. Nor was it likely to be, because there were many symbols that reinforced the right of the midwives to 'allow' and by extension 'not to allow'. One of the most obvious symbols of disadvantage was the lack of social balance in the attire of women and midwives. Women were dressed in the ultimate of casual attire, their nightdresses and dressing gowns, in contrast to the formality of the midwives' uniforms.

Production Model

The labour ward was organised to run with maximum efficiency. There were three main staff groupings, doctors and midwives (including medical and midwifery students) and healthcare assistants. Each of these groups

had its own role and responsibilities. The woman was initially questioned (either by telephone or in person) by a midwife to ensure she met the criteria for admission to the labour ward i.e. she was in labour, she was to have her labour induced or she was to have a caesarean section. She was then admitted (or not) to a labour room (and possibly later to an operating theatre) where she was prepared, monitored and subsequently delivered of a baby. (The use of the word admission on records and in speech was a powerful albeit subtle reminder to all concerned of the authority of the midwife.) The woman and her baby (accompanied by her partner) were then transferred to a postnatal ward prior to leaving the hospital proper. If the baby was not considered suitable for its mother's care i.e. it was preterm, ill, or abnormal s/he was transferred to the neonatal unit.

Inspection & Quality Control

The midwife skilled worker/inspectors

The midwives made up the majority of staff in the labour ward. They were organized into shifts under the overall control of a full time labour ward midwife manager. A typical shift was made up of approximately ten midwives of various grades (a pay scale differentiation of E, F, and G, not a professional one) headed up by a shift leader. The shift leader was chosen on a daily basis from amongst those of the highest level of grade i.e. G. The shift leader organised the work and allocated a midwife to each woman in labour. The more experienced midwives were given the women who were considered to be in more complicated labour or were more at risk. The less experienced midwives were allocated to the women considered to be at a lower risk of complications, so called 'normal'. Although the midwives were all qualified and legally accountable for their standards of care, in reality they reported frequently to the shift leader, and if they considered there was a real or potential problem they informed the shift leader and recorded the fact before they sent for a doctor. The grading was only a rough guide to experience because there could be part

time staff or bank staff working in a lower grade than they would be if they were to work full time. Once in the labour room the midwife would work solely on her own or with a student midwife. Normally no other midwife or doctor would enter except by invitation. The midwife's role in the labour room was to monitor fetal and maternal wellbeing, give support, perform physical care tasks, make records, communicate with the mother and her partner, teach the student midwife, deliver the baby and notify the shift leader and the doctor if deviations from the normal occurred. If deviations did occur she then acted as an assistant to the doctor.

The doctor technicians

The more powerful the 'gazer' the less he has to directly 'gaze' and the junior doctors worked for a consultant who in true Foucauldian style exerted a great deal of power and authority but was seldom physically present. There were eleven consultants and their teams who made up the medical staff. One consultant was the medical director and responsible for overall policy development. There were usually at least three junior doctors at all times on the labour ward. As I have described in chapter six, the doctors were the dominant group for several reasons, not least because they subscribed to the dominant ideology. They were also perceived to be in possession of the highest kind of knowledge i.e. one underpinning a positivist belief system.

The Healthcare assistants/Unskilled workers

The healthcare assistants worked directly under the direction of the midwifery manager and, on a daily basis, the shift leader and midwives. They made tea and carried out housekeeping tasks and some basic care such as bed bathing the women following birth. Although they were part of the team they were well aware of the boundaries of their work and tended to work quietly and efficiently on their own. There was conversation of an equal and social type between them and the midwives

in the coffee room. I did not hear any of them having a social conversation with the doctors although there were exchanges of a functional nature.

Use of Space

Midwives' Space.

The midwives tended to work from the midwives' station outward. This was not a place to be stationary! It was the station from which the work of processing the documentation of labour and birth began, passed through and stopped. Record keeping and computer input was carried out within its confined space. It was approximately ten feet square and usually looked very crowded. When not in the labour room itself the midwives tended to be within the midwives' station where they could be observed if the woman or men did leave their rooms. This was not in perfect accord with the panopticon but did follow it closely in that the gaze fell on observer and observed alike.

The midwives worked a short continuous shift, which did not include a meal break, but they did use their coffee room to eat and to drink coffee or tea. This was a large room to one side of the midwives' station, which contained handbag lockers, a hot water geyser, fridge and a large table. Directly opposite the door was a row of chairs and to the left of the door was the table and surrounding it more chairs. The midwives and healthcare assistants sat around the table or to the left but not usually at the same time. More often than not the health care assistants sat at the table and the midwives on the chairs at the side or visa versa. I did not realise for a while that the doctors sat in the chairs opposite and to the right, until I had sat in the doctor's space for quite a while! I was eventually made aware that I was in the wrong place by not being included in the conversations and by attempts from me being politely frozen out.

Within the labour rooms the midwife was able to utilise all or as much space as she required. This was usually all the side of the bed to the right of the mother and all the room at the bottom of the bed from the window to the door. This became her working space and fathers did not enter it. This fact was transmitted to them in various ways from direct instruction (see admission procedure later) to body language. For instance when the baby was being born a second midwife entered the room and stood at the bottom of the bed to the left of the mother and beside the father. She effectively blocked his way from moving down to the end of the bed. He then viewed his baby coming into the world from a position at the side of his partner's head and shoulders. During the labour the midwife put her records on a bedside table at the foot of the bed and to the mother's right. She and the student midwife bent over this to write up their findings. This table was left in place when they left the room and acted, as a deterrent to the father who would have had to move it to go round to look at the cardiography monitor and as a reference point for the midwife to walk to when she re-entered.

Doctors' Space

The doctors tended to sit in the coffee room until called in. Once they were summoned they entered the labour room and took over the midwife's space as their own. They thus created two new spaces from one old one, theirs and that of their assistant the midwife who then acted in a subservient position. She watched the doctor undertake tasks, answered questions regarding the state of the woman, fetched and carried equipment and acted as an assistant in the procedures.

Doctors then entered the confines of the midwives' station to look at notes and make records.

The doctors also were prominent in the operating theatre. The effect of this was to send a powerful message to the onlooker that there was a

hierarchy in the labour ward and that the doctors were higher in it than the midwives.

Fathers and Mothers' Space

As I have said the room was used on the whole as the midwife's working space and the fathers were allocated a small space for sitting and for limited movement. The women in theory could walk around the room and sit in the rocking chair or lie on the bed. In practice they seemed to sit in the rocking chair whilst in early labour and then moved to the bed and stayed there until after the baby was born. The bed could be made higher or lower by means of a mechanism on the woman's right hand side (i.e. opposite to the father). The woman could not operate it whilst she was in the bed and the father would have to walk round the bed into the midwife's space. I only ever saw this operated by the midwife. More often than not the woman lay on the bed throughout the labour with occasional walks to the bathroom. This involved quite a lot of disruption because more often than not she was linked to the cardiography machine and getting off the bed meant being disconnected from this machine. Neither she nor her partner could do this and so the midwife had to be called to disconnect her. The effect of this was to limit the woman's space and control over the environment to next to nothing. Her partner was little better. The structure of the environment and the use of space and furniture thus took away the woman and her partner's power.

The Discipline

Order Out of Chaos

The birth of a baby is a natural physiological process. This does not mean that it follows an uneventful and predictable course. Having a number of women in labour in one particular area poses quite a problem for the ordered mind because the situation can be chaotic. To superimpose order out of chaos various strategies were employed. These were manifest in rules, protocols and procedures.

Norms, Rules, Protocols, Procedures, Policies, Notices

The consultant has overall responsible for the procedures. The organisation of the labour ward is such that each person works within set guidelines drawn up as part of the labour ward protocols. Working groups comprising mainly midwives led by a research midwife and a consultant obstetrician drew these up. These were based on methods identified by the group as best current practice, and they were made available to all staff in the form of hard copies kept in folders in the midwives' station. They were also available by computer to which each midwife had regular access.

Some rules were made explicit in the form of notices such as the one on the entrance to bathroom in the labour room, which made it clear that it was not to be used by visitors. I thought this was very strange because the woman would share a toilet at home with her partner or visitors. The midwives in the focus group told me that this was because another labour room shared the bathroom. I still could not follow the logic in this because if the reason was to prevent cross infection then each woman should not have shared with a stranger. It is possible that there is another subliminal explanation in that toilets and bathrooms are powerful places in that faeces and urine are symbolic markers of territory and ownership. It is being made clear to the fathers and other visitors that this is not their space. Doctors and midwives would lose status by using them whereas fathers and visitors would gain status. (Lea 2000)

Cultural Symbols and Artefacts

Furniture

The furniture in the labour rooms was designed to be as functional as possible and yet to look as if it could be in a bedroom, homely and non-threatening. The bed was a hospital type bed with a removable head and footboard, but was covered with a floral counterpane. Each room was fairly small (about twelve feet square) and contained the bed, a bedside

locker, a bedside trolley, small wardrobe, rocking chair and one other armchair, a medical stool, two large waste bins, a cardiograph and a Perspex cot on wheels. At the head of the bed was a panel of sockets, electrical, oxygen and suction. These artefacts gave out very contradictory messages. A couple's bedroom is a sexual place where if not dominant the man is at least an equal and there is usually privacy. In this situation the hospital trappings, machinery and lack of locks for privacy countered any notion of sexuality.

Uniforms

All the staff except the consultant wore a uniform. The doctors tended to wear blue theatre trouser suits, sometimes with a white coat over them. The midwives wore royal blue uniform tunic top and navy trousers or, sometimes, blue theatre-trouser suits. The healthcare assistants wore a blue/grey dress. There were no explanatory photographs or charts on display (although the staff did wear identity cards) and so the women and their partners had to gain the knowledge of who was who by introduction or deduction. This clearly disadvantaged the women and the partners because although authority was evidenced by the uniforms the message of who, how and when to approach was not made clear.

The Gazed Upon

The Fetus- Monitoring & Cardiography

All the women that I observed in labour had the fetal heart and uterine contractions monitored at some point by means of cardiography. I did not hear anyone explaining the procedure properly or give any indication that the woman had a choice whether they received this type of care or not. The midwives regularly observed the condition of the fetus by means of cardiography and the progress of the labour. Although they made conversation with the mother and the father their prime interest was to 'view' the fetus in relation to the uterine activity. The cardiograph

monitor was a large oblong machine approximately 24 inches by 18 inches by 10 inches resting on a trolley. It took up a large area of space on the opposite side of the bed to the partner (an inanimate partner?). It was plugged into a socket on the wall and had two leads running from it to the woman. One was attached to a sensor fitted over her abdomen and kept in place by straps. The other lead was attached to a thin wire that the midwife attached to the fetal head through the cervical os. These sensors measured the uterine activity and the fetal heart rhythm and rate. The machine displayed a continuous reading and a paper printout was constantly being churned out. The effect of the machine being attached to the woman (or the woman to the machine) was to force her to lie on the bed and make her unable to move freely. It is a commanding symbol of the power of the institution on several levels. It is a medical artefact and has replaced the human midwife as the ears of institution and it has replaced the partner as the person/object the woman is most connected to. Its scientific printout reinforces the supremacy of technical knowledge and the requirement that it is present and used reinforces the bio-medical message of labour as an unsafe process.

Compliance

The Mothers

In general the women were encouraged to be quite docile and compliant, and the use of analgesia and the language of the midwife tended to reinforce this. Eight of the women in my study had been given Diamorphine as pain relief. Its effect was sedative but it also made lack balance when walking on their own. So the overall effect was a chemical restraint on women's alertness and activity. Five more had been given an epidural analgesic which, whilst not affecting the woman's state of alertness restrained her physically. The language used was maternal and infantilized the woman. Typical examples were *"pop on the bed sweetie"*

and *“just relax you’re doing fine, queen”* or *“I know it hurts but it will soon be over sweetheart”* This infantilization by language has been noted by other researchers notably Kirkham (1989) and Hockey & James (1993).

The Fathers

The fathers were neither physically restrained nor spoken to in this manner but were made compliant in other ways. These included the use of rules, space and furniture and observation of the hierarchy at work as was previously discussed. They like their partners were ‘admitted’ to the labour ward as a companion and were very quickly directed to go to the labour room. They were disciplined both by direct instructions and by the lack of information. I observed very little attempt by the midwives to conduct a proper discussion of the labour, its progress or the implications of their findings with the fathers (see later chapter). The couple was given a fragile sort of privacy because it was under the control of the midwives who entered and left the room at their own discretion. They did not say precisely when they would return. Comments were made such as *“I’ll be back in a bit but if you need me you know where the buzzer is don’t you?”*_{Obs2}. In these conditions any sort of intimacy could only be snatched at best. In Bentham’s description (Foucault 1991) of the prisoner who because he has no way of knowing when he is being watched acts as if he is always being watched. Likewise the couples did not know when the midwife would return so they might only act as if she would enter at any moment. They could be considered to act as both subject and object in the monitoring process. This does not mean that there was no resistance for as Derek pointed out he had *“nipped in and used the toilet quick”*_{po7}.

Separation & Confinement

The presence of visitors in the labour room was strictly limited to two people. On occasions other members of the family were allowed to wait in the visitors room in the foyer of the labour ward. But they were not

allowed to change over with the designated companions. This in effect meant that either the father was alone or with one other member of the family. If there were others in the visiting room he had to go out to give them information but too much walking up and down the labour ward was frowned upon or overtly commented upon. Also if the visitors were considered to be too noisy or boisterous they would be ordered to leave the labour ward proper. The father was in effect separated from his family and friends and confined to the room with his partner.

The Mother's Power

The mother seemed to have very little in the way of power or control over her surroundings. Her binary function was to be normal and compliant rather than abnormal (with complications) or disruptive (distressed, screaming, abusive, unwilling to be examined, to be monitored or to be still). She thus had the social power to give birth well or not and she had the power to choose one or two birth partners to be with her in labour. She also had the power to stay in the labour room regardless of her behaviour. She could not be asked to leave although if she wanted to she could remove herself. However that was all the power she had because she had little control over her environment although she could walk about within the room. If she was confined to the bed by being attached to the cardiograph monitor and or was sedated by analgesics she had virtually none. In general women have the physiological power to give birth without complications and in one way this was taken for granted but on the other hand there were many symbols present such as the cardiograph monitor which implied that she might not.

The Father's Power

The father did not have an automatic right to stay in the labour ward or labour room and he was made subtly and clearly aware of this. In order to remain there he had to behave appropriately. One of his binary

functions was to be harmless rather than dangerous. He had the power to ensure that he quickly ascertained how to appear harmless, what the associated, approved behaviour consisted of, and to ensure he conformed to the cultural norms. If he achieved all this he would be allowed to stay. The father is also a *gazer* upon the situation and as a relatively new comer to the institutional process may not have had too much influence as yet upon a process of decision making whereby scientific and medical authority is wielded almost unchallenged by democratic processes. However he has potential power to take future action in that he is witnessing what is going on and is an observant member of society with legal and moral rights. In a truly circular fashion he is part of 'the society' that had given assent to the Government to act on its behalf.

Alliance

In the labour ward itself the woman had two main allies. These were the midwife and her partner. As has been discussed (chapter four) the midwife's role is to give care that is woman centred and so her focus is the woman. A midwife whose profession is lower in the labour ward hierarchy and who may also be low in the midwifery grading system, does not have a great deal of individual power. However on a larger scale women's groups such as the National Childbirth Trust have formed alliances at times with representatives of the midwifery profession such as the Association of Radical Midwives and the Royal College of Midwives to ensure power is wielded for the benefit of women in general. This has resulted in moves by the government such as the Changing Childbirth initiative (DOH 1993). On both an individual and national level the co-operation of women with midwives is based on trust. Midwives have to ensure that women are convinced that they are working to give them the best care possible.

The fathers until now have not formed associations to protect their own interests in the labour ward. They are there on an individual basis for their partners and as witnesses for society as I described above. However their compliance is also based on trust of the medical and midwifery models, and in some respects their self-discipline is based on the assumption that everything is being done for the greater good of their partner. They also seem to be disciplined by their partners in that they seem to be part of the complicity of the 'shame' culture i.e. their partners do not want the men to disgrace them. My research took place before the Alder Hey scandals involving retention of child body parts (House of Commons 2000a), and the Harold Shipman murders (House of Commons 2000b). It is possible and highly likely that some trust has inevitably been lost. In the Foucauldian analysis this should result in some movement and a power struggle until a balance is once more achieved.

Conclusion

In this chapter I revisited my data to consider issues of power and the State's involvement in the birth. The various types of power were discussed and the way power is manifest through the Institution, its personnel, working practices, and the rules and regulations in order to make the birth event as controlled as possible. This seems to be aimed at making the women and their partners as compliant as possible. To do this, various strategies are employed either knowingly or otherwise. These include the use of infantilizing language and restriction of access to family members and friends. Obstetric techniques and artefacts such as use of epidural analgesia, the cardiograph and high beds complete the restriction and confinement of women. Men are also confined and made passive by the rules governing access and exit to and from the labour ward, social norms regarding behaviour, and alliances based on trust. It

could be thought that they have little or no role to play in the birthing process but this is not the case as will be seen in the following chapters, which look at what the fathers are doing in the labour rooms.

Chapter Seven. In the Birthing Room

Introduction

In this chapter I give an overview of the activities of the man, as he becomes a father from what could be described as a superficial view of the events. During the labour and delivery the man tends to recognise the authority of the midwife and yield to it by sitting in a corner and remaining fairly inconspicuous. The midwife moves between two frames of behaviour, the medical and the lay. In both frames it is clear that she is higher in authority in the labour ward in regard to the woman and her partner. An explanation of the medical and lay frames is given and a demonstration of the way the father shows his awareness of the social clues by appropriately sitting and standing in the presence of the midwife. I then analyse and examine the transcripts of the labour room observations for concepts and categories. By means of an analytical approach to the data I discover the concepts which identify the phenomena that are taking place. I discuss and analyse the behaviour of the men and attempt to throw light on the reasons for the behaviour. From an initial examination of the texts I group fragments into concepts which lead me eventually to see that there are five overarching categories which can help explain the role of the father in the labour room

The Participants

As I described in chapter two I recruited the people into the study opportunistically. I went to the labour ward at different times of day. Usually this was very early in the morning about five or six o'clock or mid afternoon. In this way I avoided the midwives shift hand over period and so they had more time to talk to me. This was important in that I needed to explain to the midwives what I was doing and that I was not there as a midwifery lecturer. It was also meant that I had a block of time in front of

me when people in spontaneous labour were likely to be admitted. (In contrast to mid morning when women would be having planned induction of labour or elective caesarean sections performed. I recruited seventeen women into the study. Two failed to become established in labour and eventually one was transferred to the antenatal area and then went home the next day, the other decided to go home from the labour ward. Two couples refused consent. All, the women, were in early first stage of labour with the fetus lying longitudinally, head presenting and no apparent complications. I would not have excluded them if there were complications other than those outlined in the ethics discussion (chapter two). However they tended to be either in advanced labour or be waiting for interventions or the midwives were reluctant to recruit them for me. After gaining permission from the shift leader I initially chose a woman using the white-board information. I looked to see if the woman met the criteria of being in early labour and then asked her midwife did she have a partner with her. This was usually affirmed with a remark such as *"they're a nice couple."* I did say that being nice was not important to me but I soon realised that this had two meanings. It conveyed that the midwife was happy to have me in the room and also that I would have a good chance of the couple agreeing to see me. The second factor was probably dependent on the first. The demographic information on the couples is presented below.

TABLE 7.1 Demographic Information

| Name | Father's Age | Mother's Age | Father's Occupation | Mother's occupation | Marital status M. = Married P = Partners | Number of Children (with present baby) |
|-----------------------|--------------|--------------|------------------------------|---------------------|--|--|
| 1.*Sally & Jack | 37 | 30 | Milkman | Shop assistant | M1 + P5 | 2 |
| 2.*Anne & Gordon | 25 | 25 | Tax Inspector | Tax Inspector | P4 | 1 (Angela) 2 (Gerrard) |
| 3. .NI Helen & George | 45 | 31 | Factory Worker | Housewife | P | 2 (Christine) 3 (Gerry) |
| 4.NIKirsty & Tim | 18 | 17 | Unemployed | Unemployed | p | 1 |
| 5. NI Susan & Luke | 34 | 26 | Plasterer | Shop assistant | P | 2 |
| 6. *Audrey & Drew | 29 | 28 | Mature student | Nurse | M | 3 |
| 7. *Joan & Derek | 28 | 27 | Cable layer | Housewife | P | 1 |
| 8.NI Jill & Kevin | 20 | 21 | Car factory worker | Secretary | P | 1 |
| 9.*Amy & Ewan | 24 | 23 | Warehouse operative | Housewife | M | 2 |
| 10. NI Rebecca & Carl | 19 | 18 | Unemployed | Housewife | P | 1 |
| 11. Cheryl & David | 26 | 25 | Ex soldier Factory worker | Housewife | M. | 3 |
| 12. Mary & Stephen | 32 | 30 | Farmer | Housewife | M. | 4 |
| 13. NI Alex & Terry | 23 | 22 | | | P (now parted) | 2 |
| 14.*Paul & Stella | 35 | 31 | Factory Worker | Housewife | P | 2 |
| 15.*Fay& James | 31 | 29 | Graphic Designer | Clerk | P | 1 |

NI = Not interviewed***** =Interviewed

Birth Process-Revisited

As described in chapter three labour, particularly the first stage can be very painful and in theory the midwife has a variety of pain relieving methods at her disposal and women can manage their pain themselves

by walking about or taking up a variety of positions. Yet during the fifteen labours that I observed the women took to, or were required to be in, bed from the active first stage of labour. All, but one, were given either an injection of Diamorphine followed by Entonox inhalant or an anaesthetist inserted an epidural analgesic. One woman used Entonox alone. I did not see women being encouraged to use other methods e.g. breathing exercises, physical or alternative remedies.

TABLE 7.2. Labour and birth outcomes

| | Name | IV infusion | C.T.G | Analgesia | Type of Delivery | Baby |
|----|----------------|-------------------------|--------------|-----------------------------------|-----------------------------|-------------|
| 1 | Sally & Jack | None | Yes | Diamorphine & Entonox inhalant | Normal | Boy |
| 2 | Anne & Gordon | IV | Yes | Diamorphine & Epidural | Normal | Girl |
| 3 | Helen & George | IV | Yes | Epidural | Forceps | Boy |
| 4 | Kirsty & Tim | IV | Yes | Epidural | Normal | Girl |
| 5 | Susan & Luke | None | Yes | Diamorphine & Entonox inhalant | Normal | Girl |
| 6 | Audrey & Drew | None | Yes | Diamorphine & Entonox inhalant | Normal | Boy |
| 7 | Joan & Derek | IV | Yes | Epidural | Caesarean | Girl |
| 8 | Jill & Kevin | None | Yes | Diamorphine & Entonox inhalant | Normal | Girl |
| 9 | Amy & Ewan | None | Yes | Diamorphine & Entonox inhalant | Normal | Boy |
| 10 | Rita & Chris | IV | Yes | Diamorphine & Entonox inhalant | Normal | Boy |
| 11 | Cheryl & David | IV | Yes | Epidural | Normal | Boy |
| 12 | Mary & Stephen | None | Yes | Entonox alone | Normal | Boy |
| 13 | Alex & Terry | None | Yes | Diamorphine & Entonox inhalant | Normal | Boy |
| 14 | Paul & Stella | IV | Yes | Epidural | Caesarean | Girl |
| 15 | Fay & James | intravenous infusion | Yes | Epidural | Caesarean | Girl |

Early First Stage

Admissions

I had received ethical approval from the hospital ethics committee on the understanding that women in labour are a vulnerable group and must not be stressed by having to face the researcher if they did not want to participate. So I was allowed into the labour room only after the midwife had explained who I was and had received the couple's agreement to see me. This in effect meant that I did not witness the admission procedure. Each time I entered the room the woman was either sitting in bed or in a rocking chair and the man was sitting in a chair at the side of the bed away from the midwife.

I asked a focus group of four midwives why the man was sitting down and how he knew where to sit and not to use the bathroom. I was told that as part of the admission procedure the midwife directs the man to sit in a particular chair and the woman to sit or lie on the bed whilst the admission recordings of history, progress of labour, temperature, and blood pressure etc. were made and documented on the partogram (record of labour). The midwives all agreed that they either told the woman to put a gown on and get on the bed or they showed the couple *"the geography of the place"*. The midwives described the process as follows;

Focus Group of midwives

- R* *Do you tell them to sit down anywhere, the chaps?*
- Mw1* *Hmmm, yeah, It depends,*
- Mw2* *Course you do. Have a seat. Take a seat or*
sometimes you make a joke and say 'you can have
the rocking chair. Or, that's a recliner there but
don't sit in it. That's for me!' Ha, Ha, Ha, Ha,

Ha, Ha, Ha, Ha, Ha, Ha, Ha. (Lots of laughter from the group)

But no, I'd always say, 'Take a seat'.

R What about bathrooms? Are they told they can't use the bathroom?

Mw1 No. Who the partners?

R Yes

Mw3 I always let them use it

Mw2 It depends.

Mw3 Yeah, on the room.

Mw1 On the room.

Mw3 Some rooms share bathrooms in which that's not fair.

Mw2 If it's an adjoining bathroom I always say to them use the one up the corridor. But if it's an end room

Mw1 An end room

Mw2 I say 'It's an end room so you can use it.'

The Midwife's Framework of Activities

I observed the midwives to be organising their activities in two of the four frames described by Peräkylä (1989) (See text box 10.1).

These were the medical and the lay

TEXT BOX 7.1 PERÄKYLA'S FRAMES OF ACTIVITIES

- 1. The practical frame defines staff in terms of the practical tasks they need to carry out in the ward; patients become the mere objects of such task.*
- 1. The medical frame defines staff in terms of the activities of diagnosis and therapeutic intervention; once again patients become objects.*
- 2. The lay frame makes staff into ordinary people, able to feel anguish and grief and it redefines the patient as a feeling and experiencing subject.*
- 3. The psychological frame defines staff as objective surveyors of the emotional reactions of patients; patients are both subjects (who feel and experience) and objects (of the knowing psychological gaze).*

Peräkylä 1989

frames. There was little evidence as defined here because all their practical activities were either diagnostic or therapeutic. If there was some movement into the psychological it happened 'backstage' out of my observation. The exception to this was the midwives comments about 'awkward' men in the focus group interview (see later).

The lay frame was most obvious at the beginning and end of the labours.

Medical Frame

The aims of midwifery care in labour are *'to achieve the safe delivery of the mother and a live healthy baby and a pleasurable, fulfilling experience of childbirth for both the mother and her partner'* (Morrin 1997). It was easy to observe the midwives trying to achieve the first two aims. There was one midwife at any one time allocated to the woman and her partner and in two cases a student midwife and one case a medical student accompanied her. The midwife conducted the admission procedure during which the woman may have had a cardiograph attached. She then left the couple to their own devices for a while. In each of the labours the midwife ensured that the woman or her partner knew how to summon help before she left. It was also made clear to the man that he should not leave the room to look for her but should use the buzzer. Whilst in the room the midwife assessed and recorded the woman's uterine contractions, blood pressure, and temperature and either listened to the fetal heart with a Sonicaid or if a cardiograph was in place she made a note of the readings on the partogram. Every two to four hours she conducted a vaginal examination and recorded her findings. If a student midwife accompanied her then much of the time in the room was spent teaching the student how to read the cardiography or to conduct a vaginal examination and record the findings in the notes. The midwife and the student midwife tended to huddle around the partogram on the bedside table and to speak in low tones with their bodies turned away from the woman and her partner. I did not see an attempt at any time to explain the notes to either the woman or the father nor were they asked

about them by any of the men or women. When the midwives were in this frame there was an obvious businesslike air about them although they were pleasant and spoke in kindly tones. This seemed to set the rules of etiquette, which were, that they could speak and ask questions but should not be distracted. When a midwife was conducting the assessments it was rare for a man to speak. (and I never heard one speak during a vaginal examination). If he did so it was in a low voice to his partner. During these encounters the men were always sitting and the midwives were always standing. Following the assessments the midwife either gave the woman and her partner a progress report or reassurance that all was well. The communication was variable even between the same midwife on different occasions. More often than not vague comments were made such as *"you're doing okay, everything's fine."*^{obs10}. This was very much in line with the findings from Kirkham's (1993) work. However following a vaginal examination the midwives all told the woman how many centimetres dilated their cervix was. It seemed to be taken for granted that this was comprehensible information. I heard nobody ask for an explanation of dilatation.

The midwives left the couples alone in between assessment visits. I did not hear any firm information given to the couples regarding the interval between leaving and the midwife's return. This put me in a quandary because I knew that the interval time would be approximately 15 minutes but could vary. A memo from the fieldnotes tells of my problem and if it was problematic for me how much more so must it have been for the couple.

Labour observations memo - Ignoring me

I found that often the midwife would enter the room without telling me. I had to sit in between time in the coffee room and so was out of the way. I thought at first that they had forgotten or were too busy but later I wondered if this was the case. Was I being deliberately excluded? I tried standing in the corridor or outside the room but I felt like a lurker and quite

conspicuous. I thought about entering the midwives' station but this was always packed. There was also an air of business and I decided against this as being too much of an intrusion.

The midwife stayed in the room towards the end of the labour when the woman started to push. She made preparations for delivery by taking packs from the wardrobe and opening them on a delivery trolley and preparing the cot for the baby. She (and the student midwife) encouraged the woman to push in each of the vaginal deliveries. Either the midwife or a student midwife delivered the baby in twelve of the women but on one occasion the doctor delivered the baby by forceps. In three cases the woman was transferred to the operating theatre to be delivered by caesarean section. (Table 7.2)

Lay Frame

In the early stage of labour the midwives apparently slipped into the lay frame quite easily. They tended to have a 'patter'. Common questions they asked were about whether the couple had any preferences regarding the sex of the baby and what names had been chosen. Existing children were enquired after and questions asked about their whereabouts and what their feelings were towards the new baby. The man was also asked about his work and this elaborated on if it was at all unusual, for example one of the men was a tax inspector and this provoked quite a lot of questions regarding the tax self assessment exercise. The midwives also answered questions put to them or offered information about themselves within what seemed to be a naturally occurring, narrow framework e.g. their marital status, whether they had children or not and if they had had normal or complicated labours. When the woman was in established and painful labour the midwife more often than not stayed in the medical frame. During the second stage before the woman was actively pushing she and the father often entered into lay conversations. One such was *"between Jack and the midwife about a copper bracelet he*

*wears and its reputed efficacy against arthritis. He said it had helped him a lot as he had suffered from this for a while until he started to wear the bracelet.*_{obs1.}

This lay frame did not reflect the usual societal meetings of men and women. For example it is not usual in society for a man to be sitting during a conversation whilst a female is standing unless he is sitting behind a desk in a demonstration of power or is in a higher position in a hierarchy and then professional etiquette may override gender etiquette. Normal social etiquette rules that a man stands in the presence of a woman and offers his seat. Or that they both sit or stand so that eyes contact can be levelly maintained. Even in today's less formal society this can be seen in public places such as bars. One of the subtle effects of power in action is the implicit agreement between the parties concerned regarding who can initiate, set the boundaries of, and end a conversation. In this situation this was most obviously within the control of the midwife.

A Pleasurable, Fulfilling experience

Morrin (1997) bases her claim that one of the aims of care is to make it “*a pleasurable, fulfilling experience of childbirth for both the mother and her partner*’ on the recommendations of the Changing Childbirth report. She considers that the midwife should enter into a partnership with the woman and “*build a relationship of mutual trust and create an environment in which expectations, wishes, fears, and anxieties can readily be discussed.*” (Morrin 1997, p.360). When the midwives were in the medical frame they demonstrated symbolically by means of professional terminology, behaviour, uniform and the use of equipment and artefacts that they were people to be trusted. However I witnessed only one midwife actually spending time to talk to the woman and her partner about their wishes_{obs5}. I did hear of women expressing their fear and apprehension regarding pain or the imminent birth and I heard reassurances from the midwives. Yet I did not hear an adult type

interactive conversation regarding fears and anxieties between any of the parties.

Behaviour/Activities

Superficially the men all followed a similar pattern of activity within the labour ward and room which is identified in the table below. They entered the labour room with their partner and were directed to sit in their designated area of the room. The furniture and seating were arranged to divide the room into various spaces. These were the working space of the midwives and doctors, the bed for the women and a small corner for the men. Their activities followed closely the course of the labour i.e. in the early first stage they stood or sat in their space within the labour room and engaged in conversation with the midwives and their partners. Occasionally they moved out of their designated area to look out of the window or to stretch their legs. If the woman wished to smoke or to go for a walk the partner accompanied her. They then walked through the labour ward to the visitor's room or out of the labour ward altogether to the main waiting area near the front door and the shop.

When the women became established in labour their partners usually remained seated in the room unless they were required to help the midwife to lift their partner up the bed. Six of the fifteen women had an epidural inserted by an anaesthetist and on each occasion the father was asked to help the woman to sit up and to hold her shoulders steady to enable the anaesthetist to insert the epidural needle into her back.

Fieldnotes Observation No. 3 Setting up the epidural

The anaesthetist (a young man in late twenties or early thirties) came into the room and spoke to Helen and then commenced to set up the epidural. He walked round to the space where Elaine (Helen's mother) and George were sitting. The anaesthetist then asked George to go round the bed. He (anaesthetist) sat down at one side of the bed and the midwife showed Helen how to sit and George where to stand. The anaesthetist then spoke to George and said, "This is your job"

and proceeded to tell him how to help Helen into position. George held Helen's shoulders and looked at the television. Elaine looked very uncertain as to where she should go. She was sitting in the space being used by the doctor and the midwife. She moved around so that she could not see the needle being inserted. There was no conversation from anybody. The midwife kept going out to fetch items for the anaesthetist's trolley. The anaesthetist inserted the needle into Helen's back and attached the intravenous infusion. During the insertion George was holding Helen's shoulders and stroking her arms in a comforting manner. When the anaesthetist inserted the needle into Helen's back George bent down and kissed the top of her head.

When an intravenous line was put up it was usually the midwife that helped the doctor but on one occasion the doctor required the father to help as follows.

Fieldnotes Observation No.4. Helping the doctor with an Intravenous line insertion

09.30am The midwife leaves the room

The female doctor begins to insert an intravenous line. Tim watches Kirsty's face during this time and then sits down to read the paper. The doctor is not doing this very well and becomes flustered. There is blood all over the sheets. She then put on her gloves and cleans Kirsty's hand up. Tim looks up and watches the insertion of the intra venous line. He then stands up and watches the doctor as she tries to organise herself. The doctor gives instructions to Tim to hold Kirsty's hand. He is standing up with a newspaper in his hand and begins to read it whilst also holding Kirsty's hand. I saw only observational behaviour. There were no comforting words for Kirsty from Tim.. He said at one point "I need a comfy chair to sit on." He seemed to be only standing and watching.

During the first stage of labour whilst sitting the men engaged in reading and eating. During the night the men often slept in the chair although one man slept for most of the first stage even during the day.

Fieldnotes Observation No.8

10.30am

Kevin is sleeping in an armchair and Jill is lying on her side having good contractions. The midwife and a medical student are looking after Jill and after they have finished their observations they have a long social chat with Jill whilst Kevin was fast asleep throughout. Following this Jill went to sleep as well.

11am

Kevin is sleeping and Jill is lying quietly coping with her contractions.

11.30am

Jill is now getting quite distressed with the contractions and asking for an epidural. Kevin wakes up a little but then goes back to sleep. Jill's mother arrives and gives her daughter a kiss and a big hug. Kevin is still very sleepy.

Each time I saw a woman begin to actively push in the second stage of labour the midwife told the man to stand up. I did not see a man stand up without being told to do so. He was then more often than not directed to put his arm around her shoulders and to support her in a semi recumbent position as she pushed. This had the effect of keeping the man at the head of the bed so he was looking down on his baby being born from a similar vantage point to that of his partner. Each time the baby was born vaginally another midwife entered the room around the time of birth and stood on the opposite side of the bed to the midwife conducting the delivery. Her body in effect prevented the man from moving down the bed to view the baby being born from an observational position. And on at least one occasion *"the second midwife is called and takes her place at David's side obliterating his view if he desired to look"*.

When the baby was born the midwife delivered the placenta and all but one of the men spontaneously sat down looking over to his baby or he walked over to the midwife and his baby. The odd man out was asked to sit down by the other midwife. At this point the midwife or student midwife delivered the placenta. She then cleaned away the wet bedding and either then proceeded to suture the woman's perineum or cover her up with a small sheet. In the case of the woman who had a forceps delivery the doctor proceeded to suture her perineum and then the midwife helped him to take the woman's legs down from the lithotomy poles and then the midwife took over her care. The men did not stand again until the birth process was completely finished and the women were sitting up in bed.

So far in this chapter I have examined the behaviour of the midwife and showed how she moved mainly between two frames of behaviour that of the medical and the lay frame as described by Peräkylä (1989) according to the stage that the woman was at in her labour. She moved almost equally between the lay and the medical when the woman was in the first stage of labour, not in too much pain and was still in a communicative mood. However this lay frame was not completely unreserved because both the men and the women were made to know in various subtle ways that only certain topics were appropriate. For example it seemed quite clear to me as an observer that the topics which were appropriate were to do with the midwife's status as a mother and certain related aspects such as whether or not she, the midwife, was married. Other social aspects of the midwives life for example her interests and lifestyle were not touched upon. There was a power differential and that the midwife was in a superior position to the couple. This was evident for example in the way the midwife directed the couple to take up their places in the space, told them the rules were regarding bathroom use and instructed the man not to leave the room unless necessary, whilst she, the midwife, could and did enter at will. Also the midwife asked the man to sit down and the

woman to either lie or sit whilst she remained standing and so she was both actually and symbolically in a superior position. During the intense part of the first stage the midwife remained in the medical frame. To some degree when the woman was in the second stage of labour and she the midwife remained in the room rather than exiting after conducting an assessment of the woman's condition she returned to moving between the lay and the medical frames. From a superficial observation of the conduct of the men it could be argued that they were socialized into the role of passive observer and sometime assistant to the midwife and doctor.

However after I conducted a line by line conceptual analysis of the fieldwork data (initially manually and later by the Win Max Pro computer package) I realized that the men were actually doing more than this. The concepts were examined and reduced into overarching categories that enriched and enlightened the process and will be discussed in the next chapter.

Initial Organisation

As previously described I took the broad categories from the quantitative questionnaires and developed a very loose observational schedule. The categories were the context, the activities of the father, education/information seeking behaviour, family support, feelings, and danger. I used these categories to structure the first

TEXT BOX 7.2

INITIAL BEHAVIOURS/CONCEPTS

Knowledge I

Information seeking behaviour

Education

Supportive behaviour

Team member

Social norm compliance

Bargaining

Advocates

Monitoring/management

Distancing technique – self & others

Professional relationships

Context/machines

observation. It quickly became apparent to me that this was not a fruitful way to proceed because I was so busy trying to identify which category events came under that I was in danger of not recording matters which could perhaps be important. From the second observation onwards I recorded everything I thought relevant. I did however keep the behaviour and/or concepts that were becoming more obvious listed at the top of my notebook (see Text Box 7.2) just to ensure that I did not miss anything valuable. The field notes were transcribed as soon as possible and initially I went through them line by line and conducted a process of open coding (Strauss & Corbin 1990). I fractured the data by highlighting words and phrases on each line and identified them as concepts in the margin or ‘*named the phenomenon*’ (Strauss & Corbin 1990). A short example of this is given below.

| Text Box 7.3 Initial Open Coding Observation No.1 | | |
|---|--|----------------------------|
| <u>LINE</u> | <u>TEXT</u> | <u>CONCEPTS</u> |
| <u>NO.</u> | | |
| 52 | <u>Jack was stroking her arm</u> and he <u>fetches a drink of</u> | ARMSTROKING & NURTURING |
| 53 | <u>Water. She complained a lot about being dry</u> and <u>Jack</u> | PHYSICAL |
| | <u>gave</u> | NEEDS |
| 54 | <u>Her drinks and ice to suck. The ice made her feel sick</u> | FEEDING & |
| | so | NURTURING. |
| | | PHYSICAL |
| | | PROBLEMS |
| 55 | She asked for mints. <u>Jack had a supply on the bed</u> | FEEDING & |
| | <u>table</u> | NURTURING |

I later expanded on this method by putting the transcripts into text form, transporting them into WinMaxPro and generating the concepts by means of a computer. This enabled me to organise the concepts into groupings

and to retrieve portions of text more easily. An example of this is given in Table 11.2. Throughout the recording and analysis I made memos of significant events or questions that occurred through reading the data, to guide my thinking. I then followed Strauss and Corbin's (1990) system of axial coding. I engaged in the three steps of, concept reduction, selective sampling of the literature and purposive sampling of the data. After repeated examination and re-examination (axial coding), memo writing, grouping and regrouping and deeper analysis and interpretation of the data I developed the five core categories which form 'the story' or theoretical construct. These are, Alliance Formation, Protective Vigilance, Supportive Championship, Linkmanship and, Becoming a Father. Textbox 7.4 exemplifies the steps in the arrival at Alliance Formation.

| <i>TEXT BOX 7.4. The concepts leading to the formation of the core category of Alliance Formation</i> | | |
|--|-----------------------|----------------------|
| <u>Open Coding</u> | <u>Concepts</u> | <u>Core Category</u> |
| Chat between Jack and the midwife Social conversation Chat about full or shortened names | RELATIONSHIP BUILDING | ALLIANCE FORMATION |
| Talking about the last birth Said he had fainted last time Telling about the last labour | TELLING HIS STORY | ALLIANCE FORMATION |
| Talk about their house talk about his studies Told me he worked in G as a plasterer His views are about his role | BEING A PERSON | ALLIANCE FORMATION |

Each core category is an overarching organisation of the behaviour that is observable and can be seen to have conditions, properties and dimensions and to be purposeful and goal orientated.

An example of generated concepts and their fit into the five core categories are given in Text Box 7.5

TEXT BOX 7.5 Examples of the relationship between the concepts following open coding and the final five core categories

| CONCEPT | | CORE CATEGORY |
|-------------------------|---|----------------------|
| Relationship building | } | ALLIANCE FORMATION |
| Being a person | | |
| Marginal role | | |
| Being an outsider | | |
| Fathers space | | |
| Compliant | | |
| Excluded | | |
| Power/authority | | |
| Face watching | } | PROTECTIVE VIGILANCE |
| Observant | | |
| Procedure watching | | |
| Watching for the baby | | |
| Information seeking | | |
| Nurturing | } | SUPPORTIVE |
| Intimacy | | |
| Physical support (care) | | |
| Privacy | | |
| CHAMPIONSHIP | | |
| Advocacy | | |
| Standing | | |
| Pain | | |
| Family | } | LINKMANSHIP |
| Family support | | |
| Communicator | | |
| His needs | | |
| Link with home | | |
| Birth | } | BECOMING A FATHER |
| Baby | | |
| Emotions | | |
| Rituals | | |
| Relaxation | | |

The Core Categories

Alliance Formation

It has been documented (Walton 1994) that the women are undergoing a rite of passage in labour i.e. separation, liminality and reintegration and that women in general are 'invisible' (Ardener 1981). What has usually

not been considered is that men are also undergoing such a rite. They are also separated from their families, friends and traditional means of support and are confined (literally) in a small space within the labour room of a labour ward. In addition they find themselves in a situation in which all the social norms and means of self-management are different. They are in a segregated time zone i.e. the activity continues for twenty-four hours and is based on unpredictable labour time (the rhythm of the labouring woman's uterus). They are in a

Text Box 7.6.. Some examples of exclusion of the fathers

- No.1 *The midwife then went out and returned with a female doctor. The doctor stood at the foot of the bed and introduced herself to Sally. She did not speak to or acknowledge Jack.*
- No 3 *The anaesthetist (young man in late twenties or early thirties) came into the room and spoke to Helen ignored George and then commenced to set up the epidural. The midwives and another doctor came in and introduced herself to Helen but did not seem aware of George's presence.*
- No 4 *The midwife performed an artificial rupture of the membranes whilst Tim was out of the room.*
- No 5 *A doctor (male) and explained the hazards of induction to Susan. He did not speak to either Luke or the mother.*
- No 7 *She almost excludes his view with her body. She mops Joan's brow and holds her hand throughout the procedure.....She speaks briefly to Joan but not at all to Derek*
- No 11 *The anaesthetist does not talk to him but looks at Cheryl's back and then leaves the room.....The second midwife is called and takes her place at David's side obliterating his view if he so desired*

powerful organisation in which they have very little power and one in which they are the 'invisible' people rather than the (predominately)

female midwives. This is recognised at a subliminal level (as Frankenberg (1986) pointed out in relation to the making social of disease). The men in this study employed various strategies to form an alliance with the midwife because as they said in various ways at interview they felt excluded and marginalized.

This exclusion was observable in the labour room (see examples in Text Box 7.6) but was mainly done by the doctors.

Relationship building

A process of relationship building started when the couple arrived in the labour ward (or sometimes even before) and was vital to being seen by the midwife as a non-threatening socially compliant person. The relationship building followed a pattern in that the men were asked to sit down whilst the woman was examined and the midwife undertook the baseline observations. The midwife was usually standing and the man sitting and the talk covered topics such as his feelings towards the birth; *'there was some social conversation about the baby and the names they had chosen – Natasha or Jacque'* obsno2, Or they were about his job; *'he talked about his previous job when he was working in Europe'* obsNo 5 and the couple's other children *'there was some talk about their previous baby'* obsNo13.

Being a person and telling his story

The men's talk fell into two broad divisions which I labelled 'being a person' and 'telling his story'.

'Being a person' referred to the type of disclosures the men gave about themselves as people and was more often than not given by first time fathers. These covered such things as how they felt, for example Jack who said, *"he felt unimportant"* obsno.1. Or it was about their interests as in this extract *'Derek is talking to the medical student about running and football'* obsno7. Or yet again about their home and the preparations for the baby *'they said they had bought 'everything' and the baby's room was yellow with everything in it all ready'* obsno. 7. Telling his story referred to

the way the men who were already fathers tended to tell the midwife about his experience of being at the previous birth or the difficulties that had to be overcome to be there currently. For example *'He had been with Helen for eleven years and has one son by his first wife, who is now seventeen years old. He had been at his birth, which had been normal. He had been at Helen's last delivery which was by caesarean section'* ObsNo3. Difficulties such as having had no sleep for two nights ObsNo11 or the difficulty in getting away from work abroadObsNo5 were talked about.

Compliance

All the men I observed were compliant and outwardly passive in that they sat where they were required to and did not move about the labour ward whilst the midwives and myself were present. On the whole they were quiet and remained seated as some of these extracts (Text Box 7.7) from the field notes show. In general they were pleasant and smiling and extremely cooperative in that they bowed to the midwife's authority. For example when the midwife said to Tim *"bring your chair round here"*ObsNo4 OR when the midwife told Kevin *"not to be so silly"*ObsNo8 OR Paul to *"stay where you are and rub her leg"*ObsNo15 her authority was not questioned.

| TEXT BOX 7.7. | |
|--------------------------|--|
| LABOUR WARD OBSERVATIONS | |
| No.1 | <i>He is in a sitting position in the low armchair at the side of the bed.</i> |
| No.2 | <i>Gordon sat at Amy's left side</i> |
| No.3 | <i>He then sat down at Helen's side</i> |
| No.4 | <i>Tim was sitting in an armchair</i> |
| No.11 | <i>He is quiet with a pleasant manner</i> |
| No.14 | <i>James is quiet and watchful.</i> |

This outwardly compliant behaviour was in fact purposeful and goal orientated for as Goffman (1974) pointed out individuals seek to acquire information both verbally and symbolically about others to enable themselves to know in advance what to expect of each other. The midwives were very clearly showing that they were to be thought of as

trustworthy, friendly, professional people. The men on their part were subtly negotiating to gain and maintain a place in the labour room. In order to win the trust of the midwives they had to be seen to be non-threatening, pleasant and useful to both the midwife and the mother. This was achieved in part by the low body position, smiling and pleasant manner (Text Box 11.6) and the impression that they were real people with lives outside the labour room who were caring home lovers and family men. Some were able to describe how they had been in the situation before and to signal that they would not act inappropriately in the current situation. A common way of disarming the midwife was by the use of joking. Douglas (1999) in her analysis of jokes says that *'all jokes have a subversive effect on the dominant structure of ideas'...*and, *'it changes the balance of power'*. The jokes tended to be self-deprecatory and again it seems that they were another way of signalling that the men were not dangerous. On occasion they were inclusive of the couple as when *"Terry says 'We breed devils' and Alex says 'Yes. We have the recipe for disaster'"* ObsNo13. Usually the rite imposes order and the joke disorganises and the most disorganising joke is that of scatology. However in this situation whilst the midwife was imposing order on the unknown of labour the men were not making jokes about the bodily functions nor about blood, sexual parts or danger. In this case they were too close to nature and the woman's body was in a symbolically marginal state and perhaps in too much need of rite and organisation to be involved in the joking process. Two men were familiar with hospital life because their relatives were nurses. It was noticeable that they were both very comfortable and at ease with the midwives. In one case the woman in labour was a nurse and she, her husband and the midwife talked very comfortably about staffing situations, pay scales and a particular genetic condition. In contrast one very young man was very ill at ease and *"monosyllabic"* ObsNo4.

Consequences of not forming an alliance

The consequences of not acting in an acceptable manner ranged from the possibly of being treated with icy politeness to the prospect of actual ejection. The following extract from the field notes show how a father upset the midwife even before he came into the hospital. It is difficult to believe that rapport would have been established in this case.

Extract from field notes - Backstage in the coffee room

A midwife came in from the midwives' station into the coffee room and said one man was being very awkward. He had been a bit rude to her on the phone prior to the woman's admission in that she asked to talk to his wife and was told she was in the toilet. When the midwife asked to speak to her he said 'She is on the toilet'. The midwife then asked would she ring back. She did not. They arrived and he started to look at the board (it has all the women's names and progress written on it). The midwife asked him not to do this and to go into the room. She then asked the woman how often her pains were coming. She said every two minutes and he corrected her saying every 4 minutes. This midwife said that she thought some men were abusive to women. She said she considered it abusive if a man shouted at the woman in labour telling her to do as the midwife told her.....

In reality ejection from the labour ward was a very unlikely event as the midwives in the focus group explained (see below). It seems that the women themselves police the situation and if the woman considers her partner unfit to come to the labour ward for example if it is night time and he has been drinking earlier in the evening then more often than not she will come alone. *"Because women are quite strong and proud."* *FO*. Sometimes if he is allowed to come then according to the midwife *"If he is happy drunk he may just sit in a corner and sleep"* *FO*. Even if the security guards are called they will in the first instance try to calm the man. The midwives considered that the people who were most irritating were those that did not want to be there and did not want to be involved.

Extract from Focus Group interview

- R *"What do they do and how do you deal with it or do you just put up with it?"*
- Midwife *It depends, If. Yes if their obnoxiousness is interfering with my care for her then yes. I think I have only done it (ejected men) once or twice, you know. But prior to that there have been lots of sort of warning you know that I have said, "You know I am finding you quite threatening or, could you do ...?. I am just trying to look after your wife or whatever and could you just try and ...and if that carries on and carries on and is interfering then once or twice I have.*
- R *How did you find them threatening? In what way?*
- Midwife *This is very unusual but that they are so stressed that they are aggressive especially when there has been prolonged labour and she is in pain and he is so stressed and it is like "I want the f... doctor in here now'. Before today we have had to get security. That person was actually on drugs. It is awful for the woman in labour. She does not need that!"*

Protective Vigilance

Observation

It quickly became apparent to me that although the men were quiet they were not actually passive. After open coding of the data it can be seen (Text Box 7.3) that the men were spending a lot of the time in activities relating to observation. They either watched the midwife and doctor or they watched their partner. When the midwife or doctor entered the room and began their examinations or routine baseline measurements or filled in the records the fathers started to watch the procedure very intently. It could be argued that the men were merely observing the event but it seemed to be a very attentive procedure where the man was actively alert and watchful. One man in the follow up interviews was adamant that he was not an observer for as he said.

"So partly your role is sort of watching what's going on, and just you know, you don't know enough, you know, medically and hospital wise to necessarily, you know, you can't intervene in a procedure or anything, but at the same time it's your child that is being born" po6.

He was intimating that he felt very much a part of the process and that his role was to watch intently. This is what I saw all the men doing (even the one who dozed a lot acted in this manner when awake) They were being vigilant and on guard. This was even the case with one very young man who tended to hide behind his newspaper a lot. *"Tim watches the insertion of the intravenous line and then stands up and watches the doctor as she tries to organise herself"* ObsNo4. This particular father had been distancing himself quite a lot but jumped to his feet as he saw the doctor struggling with the procedure.

Face watching

The fathers also spent a lot of time intently and fixedly watching the woman's face when she was having a contraction or when she was being examined or having any procedure. The expressions on their faces at these times were usually those of concern but on the whole tended to be more watchful, alert and wary. They were monitoring the women closely and looking for signs of pain and distress. Although they did glance over the women's bodies at times they tended not to look at the woman's genitalia except when directed to by the midwife. This occurred when the man was standing helping the woman to push and the head was advancing one of the midwives present for example, *"He is watching for the baby very intently now"* ObsNo13 and *"Terry looks when told to"* ObsNo13. It was unacceptable for him to look at any other time. On one occasion a man got up from his seat and walked to the bottom of the bed whilst the midwife was rupturing his wife's membranes.

"She tells Joan that the liquor is clear but there is little progress now. Derek gets to his feet and goes to stand at the bottom of the bed looking at his wife's vulva. The midwife

*notices and covers it up with a pad and then the bed sheet"*ObsNo7.

They were actively watching rather than being there as passive observers but the watching was about the forthcoming baby. There was an implicit and in this case reinforced understanding that the birth was to be treated as a non-sexual event.

Knowledge and information seeking behaviour

The men tended not to ask the doctors any questions but either asked the midwives about the progress of labour or about things the doctors had said or done when they had left the room. Questions were generally about time and progress i.e. how long the labour had to go and was everything proceeding satisfactorily. The midwives tended to use reassurances rather than giving facts in answer. Some men like Gordon thought they had enough knowledge to be helpful. *"Gordon spoke about his role and thought he had enough knowledge to be helpful when labour progresses"* ObsNo2. Even so both he and the rest of the men asked questions for example,

*"he asked about a swelling that the doctor had pointed out to the midwife"*ObsNo3 and *"James asks a lot of questions about the length of time the epidural takes to take effect"*PoNo14.

The exception to this was one young man about whom I noted at one point *"Information seeking behaviour: There is none observable"*PoNo9. The information was usually discussed and sometimes he then explained to the woman after the midwife had finished speaking. In this way the man was acting as an intermediary.

Distancing

Interestingly the men, even whilst being vigilant and protective, distanced themselves at times. Distancing occurred very frequently (noted on 64 occasions). This more often than not took the form of staring into the middle distance, at the window or the television when the woman was

being examined vaginally or being given an injection or having an intravenous needle inserted. Occasionally and unusually it was overt as this excerpt shows *"The midwife delivers the placenta and Kevin makes a face and noise as if he is being sick and turns away"* Ob₁No8. However sometimes it was because they were reluctant to move furniture as when Derek and Joan sat facing each other with the bed between them Ob₁No7 or Chris's sat in a chair 3-4 feet away from the bed Ob₁No10. The youngest man Tim picked a newspaper up whenever we entered the room. At first this seemed very strange behaviour and my field note read *"would a man read the paper in his own home when his wife is in pain?"* Fm4. However it became obvious that this was a distancing and self-protective measure. On closer observation I also became aware that he was watching the procedures over the top of the paper.

Some used the time between the midwife making her observations or examinations and leaving the room to distance themselves literally. They used this time to go to the toilet, shop or telephone. Rather than being a gap filler for the midwife as the literature suggests two men in actual fact told me that the midwife was the gap filler for them. They felt safe to leave the woman for a short time in the midwife's hands.

Distancing seemed to serve two functions. It seemed to mean that the men could still be protective and vigilant and yet could remove themselves from the situation if it became difficult for them to watch. The private of their bedroom had become public which may have been very difficult to handle. It is likely that the men had never been in a situation where their partners had been unclothed and exposed with another person present. They seemed to be also in a way protecting their partners from undue exposure at a vulnerable time.

Supportive Championship

The fathers behaved in ways which could be considered under the concepts of nurturing, intimacy, eye contact, physical contact (care), moral support, privacy, verbal support, standing, active position, pain,

and sharing. After the inductive and deductive process of axial coding it seemed to me that they fitted into a category of *supportive championship*. A supporter can be fan who gives allegiance, verbal and moral support and urges one on to the goal or he can be someone who has a supporting part in a drama. A supporter can also be someone who gives actual physical support. In this case the men at various times fulfilled all the criteria. One's champion is someone who takes one's side and is one's defender or advocate, and the fathers also certainly acted as this.

Supporter as fan

A common theme to the initial interviews was that the fathers just wanted to be there "for her" and this was very obvious in the way that they gave verbal and moral support to the women. I heard all the fathers constantly making encouraging remarks to their partners. For example "You are doing really well . You are nearly there." ObsNo 13. "Yes, You have got your colour back now" ObsNo 10. "All the time he was standing up, encouraging her" ObsNo 3. "Come on love, it's going to be alright" ObsNo 15. These are typical of the type of encouragement that the men gave over and over again. It varied from very quiet whispers of support to very actively standing and urging her to push. On one occasion the man got so carried away that the midwife had to tell him to stop (observation No 3).

Supporting part

The man was becoming a father in the labour room and as such had a part, which, although not central, was certainly not peripheral. Several of the men in the interviews had expressed the desire not to be a 'spare part' and to some extent this depended on the midwife. When the alliance with the midwife was working well he was included as much as possible and one midwife in particular (observation five) went out of her way to include him in all the conversations (how much that was due to my presence I cannot tell). Some of the ways this was achieved was by the man being given small tasks to do such as replacing the Entonox

inhalant mouthpiece, pushing a button, turning off the IV infusion or helping the anaesthetist by holding the woman's shoulders. The literature talks about the man being used as a subordinate, well-behaved member of the team to help keep the woman under control (Kitzinger 1991). I did not form the impression that these tasks were for that purpose. Instead they seemed perfectly natural things to ask as the midwife was on one side of the bed and the man was on the side with the intravenous infusion etc. and they also brought him into the main stream of the event. They also gave him something to do which could be construed as the midwife demonstrating her power and treating the man as a child. Or it could be that he is 'unknowing' in the presence of the 'knowing' and so can only do the unskilled 'caring' jobs that women usually do.

Support giver

The fathers gave the women support in various ways but mainly through physical contact and care, physical and verbal support, and nurturing

behaviour. It was very obvious that the men were trying to help the women with the pain and discomfort of labour. As I noted in an earlier chapter it was not always possible for the man to hold the woman's hand if she had an intravenous infusion needle inserted into the back of her hand. However I noted that all the men demonstrated tenderness and caring in physical ways such as stroking their partner's hair, face, arms and legs, massaging her shoulders, kissing her hand, cheek or head,

TEXT BOX 7.8

Some examples of physical contact and intimacy

No.1 He is gazing into her eyes.

No.2. Sitting with Amy holding her hand

No.3 He was smiling and looking at Helen

No 5 Sitting holding hands with Susan dozing.

No. 11 David is very supportive, holding her hand

No. 11 He hugs Cheryl

No 12 Stephen is stroking her face and looking into her eyes.

No. 14 He is stroking her arm

No 15 James is hugging her and she is clinging to him.

rubbing her back, tousling her hair, hugging, holding and rocking her, (for examples see Text Box 7.8). Very often during this time there was eye contact between the couple. This was a private and intimate act and quite unlike the face watching as previously described. The labour was the outcome of a sexual and private act and was being performed in public, and although some writers (Kitzinger 1983, Flint 1984, Walton 1994) have drawn attention to the need for sensitivity and privacy in labour there was no opportunity for behaviour of a deeply intimate nature. The labour rooms were not capable of being locked from within and the midwives entered and left at will. The midwives tended to be busy with their record keeping or procedural interventions and whilst not ignoring the couples tended not to intrude on these moments.

On the whole the men were solicitous of the women's comfort. They helped them to sit up in bed, supported them as they walked to the toilet, helped them in and out of the bath, straightened the bed sheets, supported their backs as they pushed in the second stage of labour and wiped their faces as the following excerpts show;

TEXT BOX 7.9. *Support giver*

- | | |
|-------|--|
| No.1 | <i>Being helped back into bed by Jack</i> |
| No.3 | <i>She was slipping down the bed and George helped lift her up</i> |
| No. 6 | <i>He wiped her face with a damp cloth</i> |
| No.9 | <i>He is helping her with the Entonox inhalant</i> |
| No 11 | <i>David helped her to walk to the toilet with the assistance of the midwife</i> |
| No 13 | <i>Alex is small and he lifts her up easily</i> |

In the pre labour interviews some of the men thought they would be there

to take abuse from their partners. I saw very little of this except in Observation number 6 when Audrey began to dig her nails into Neil's hands when she began to want to push at the end of the first stage of labour. Kirsty also commented to us that Tim was very good. She *"talks about how he takes it when she 'snaps' but he is understanding. This puzzles me because I haven't seen her snap. Perhaps she grumbles at him when they are alone."* ObsNo 4.

Nurturing

One of the caring behaviours that the men showed was that of nurturing. Officially it was the hospital policy not to allow the woman to eat once they were established in labour. However all the men helped nourish the women in small ways. They gave them mints to suck, sips of water or orange juice to drink, and ice to suck upon. In early labour they sometimes went to the shop and returned with sweets and chocolate for the women. (ObsNo6, ObsNo10, ObsNo14) On one occasion Tim who had given Kirsty sweets all the way through the labour popped a piece of chewing gum into her mouth just as she started to breathe in deeply and push. I held my breath in case she choked but it did not seem to bother her. ObsNo4. Neither the midwife nor myself was ever offered anything to eat.

Just as language is a code so is food and *"the messages it encodes will be found in the pattern of social relations being expressed"* (Douglas 1999). It expresses a social relation of inclusion and exclusion and in this microcosm the midwife is excluded and the couple included. In as much as the main food being offered was liquid i.e. water or juice it did not constitute a meal. It is also not possible to say the offering and sharing of mints and sweets was a meal. This is because according to Douglas (1999) a meal consists of solid food plus a drink with at least one mouth entering utensil and a number of contrasts for example hot and cold, or bland and spicy. In this case the food was invariably cold and sweet and involved no utensils. It fell into the same category as cocktails which are

social occasions involving strangers in *"the detachment and impermanence of simpler and less intimate social bonds"* (than in the simplest meal) Douglas (1999). The couple either brought in the food itself or the man went and bought it on site. It was not provided by the Institution. However as the midwife was not included in the offering and sharing it seems that this was an activity more intimate than the cocktail party. It linked the man to the woman by means of a private act within a public arena. The activity was bounded, structured and exclusive and if food can be likened to sex it was also regulated and constrained in a similar way to the desexualization of kissing as witnessed in the public forms of intimacy such as the kissing of the top of the head.

Championship

One way for the man to support his partner was to be her advocate or champion. This happened very often but not in any dramatic way (that I witnessed). It often took the form of informing the doctor or midwife that his partner was in pain or needed something or could cope no longer. Very often the woman used the man to confirm her statements, for example, Anne seemed tremendously frightened of pain. When she was in very early labour she told the midwife over and over again that she could not stand pain and would need a strong analgesic or an epidural and called on Gordon to confirm that this was true. When she did start having strong contractions she told the midwife and *"she was telling Gordon to confirm that she could not stand pain. He agrees and told the midwife that Anne was in a lot of pain"*.ObsNo2. or again *'David confirmed what she was saying about the length and strength of her contractions'*ObsNo11. On three occasions the labour ended with the woman having to go to theatre for a caesarean section. In each case the man had become quite intense and agitated on her behalf before the decision as made and following the decision asked questions about the procedure and the potential outcomes for his partner.ObsNo7, No 14, 15

Linkmanship

The woman in advanced labour was not able to leave the labour room. She was truly separated from the outside world, confined and was as separate as an initiate in a rite of passage. The man on the other hand was not truly an initiate because although he was confined to a degree he could and did leave the room to make contact with the outside world. He acted as a link between the inner sanctum of the labour room and the outer world of family and friends. It was evident that the men were in communication with the family. There was a portable phone on the labour ward proper, which tended to be acquired by the midwife or the healthcare assistant after the baby was born to enable the woman to talk to her family. Before the birth it was more usual for the man to leave the labour room and use the public telephone outside the labour ward. This usually occurred after the midwife had completed her examination but not before she had left the room. It was evident that the woman had a network of supporters who were waiting for news of how she was coping and of the birth. When the man returned he usually gave the woman a resume of his conversation. This often entailed a message of love and support from parents and relatives. In some cases the family and friends were waiting in the visitor's room or outside the labour ward in the main corridor. Their behaviour was seen as the responsibility of the man and it was up to him to ensure that they did not breach behavioural norms. This meant in effect that they stayed within the visitor's room, did not make too much noise, did not harass the midwives and did not obstruct the entrance to the labour ward. On several occasions I witnessed inappropriate activities. On one occasion two women and a man were verbally abusing a midwife and demanding (with foul language) to be allowed in to their friend. Another time several people were milling around in the foyer and a midwife manager ordered the healthcare assistants to ask them to leave^{FN3}. The midwives saw the protection of the women and the smooth running of the labour ward, as their priorities

as the excerpt below makes clear. However it is interesting to see that midwife one seems to be contradicting herself in that although she initially says that there should be no restrictions on visitors she then goes on to describe how they can be a nuisance.

Extract from Focus Group Interview

- Midwife One* *I think there should be no visiting restrictions for everyone.*
- R* *Why is there?*
- Midwife One* *I think it's just that the labour ward is so big*
- Midwife Two* *And just because of the general traffic up and down the corridors*
- Midwife One* *Or what is the word I am looking for?*
- Midwife two* *Logistics?*
- Midwife One* *No, and in like, in (this city). you would have the neighbours and everybody here. I took somebody for a section a few weeks ago and when we came out it was like when you see these film stars sort of arrive at Heathrow, and a swarm. That is what it was like. I am not joking. All running. all round the bed. All the way round the bed. All these people running down the corridor. It was such... Swarms and swarms of people. I could not believe it. I just stood there thinking "Oh my God". Now this woman had had like a twenty four-hour labour and she was lying in the bed after a G.A. and the kids, the nans!*
- Midwife Two* *It's the mentality, I want to be the first to see her!*
- R* *And that actually happens?*
- Midwife One* *They would all be in and out, in and out and for safety it wouldn't necessarily..*
- Midwife Two* *And you know*
- Midwife One* *And after doing my (project) they don't want everyone there. They want a select.. But they. It may be a Northern thing but I have noticed there are a lot more extended families.*

On the whole the visitors that I witnessed were quiet, unobtrusive and overall very patient. They could be in the visitor's room for hours at a stretch and even then might or might not be admitted when the baby was born. For example after Chris and Rita's baby was born, *'Chris wants his own father to come in. Adam is his fourteenth grandchild and the first boy. The midwife says 'Sorry', and suggests they might wheel the baby up to him in a short while'*ObsNo10. The rules of the labour ward said that woman's partner and one other person could accompany the woman. Changing over was not allowed and I did not see this rule broken. In fact I saw one man being sent out to tell his wife's father to go home. It was early afternoon and the man had come from work but was not allowed to see his daughter because his wife, her mother was already in the labour room ObsNo7. The man's fragile right to be in the labour room could be jeopardised by the visitors so he needed to be successful in acquiring knowledge of the unwritten rules of visitor behaviour and managing his company successfully.

Aside from acting as a communication channel, linkmanship offered the man some support for himself. For example James's mother brought him sandwiches and Derek's father came with lots of change for the telephone. It is possible that their relatives showed a welcome concern for their well being. Although they may have gone without sleep for over twenty-four hours it was not done for a man to complain and if they did, there was little if any sympathy from the midwives. In fact I only twice heard men being asked if they were okay and these were times when the woman was having an epidural needle inserted.. The first was by a doctor *"the registrar (a tall man) asks if he is okay. He replies 'Yes, thanks'*ObsNo11." On the second occasion *"when the midwife A asks him if he is alright he looks surprised and says 'Yes I'm okay'* ObsNo13. If a man did mention that he was tired, as Derek and Chris's did their remarks were ignored completely. One man Kevin slept a lot and caused raised

eyebrows from the midwife. It is likely that this could be seen as unacceptable behaviour because the men were supposed to be interested and willing participants as one midwife disclosed:

Extract from focus group interview-

Midwife

"But I think more than really aggressive people, it's more the people who aren't really bothered and don't really want to be there that are irritating. I mean you wouldn't necessarily, you wouldn't act on it at all except to try and involve them and if he doesn't want to be involved then he doesn't want to be involved. But that is more common." .FO.

Becoming a Father

The birth emotions

In all the labours when the woman began to push in the second stage of labour the man stood up. He either spontaneously began to help her, or he was guided by the midwife for example "the midwife gives Kevin lots of instructions on where to stand and how to support Jill's head" obsNo8. This was the period of greatest intensity. The woman became very active and in all of the births (including the forceps delivery) I witnessed she was in a semi recumbent position being supported by her partner. He was always standing at the top of the bed facing her feet. In all the cases the man had his right arm around the woman's shoulders supporting her as she actively pushed. So his view was from the same point as his partner except that because he was standing he had a better view of the birth area of the bed. Usually the woman pulled her legs up towards her abdomen herself but sometimes her partner pulled up her left leg with his left hand. On one occasion obs No 3 he got carried away and was pulling on her leg with such enormous force that she was in danger of having her hip dislocated. In all cases the midwife summoned for a second midwife who came in and prepared to receive the baby. She stood on the man's side at the bottom of the bed and in some cases excluded

his view as in the case of DavidObsNo11 and Kevin ObsNo8. I did not hear any of the second midwives say why they had come in but as in Sally and Jack's case when *"she began to get a towel and labels"* ObsNo1 it became obvious. She also gave the mother an intramuscular injection of Syntometrine 1ml into her leg as the shoulders were being born. As the head advanced the midwife sometimes told the couple to look. When she said this to Cheryl and David, *"Cheryl looked down but David looked fixedly at her (Cheryl's) face"* ObsNo11. In all the deliveries there was an air of hushed anticipation and excitement at this time. Sometimes the midwife told the man to look at the baby being born as she did to Gordon. *"The baby was being born and the midwife told him to look. He did so and started to tell Anne what he could see"* ObsNo2. In four cases ObsNo1,2,3,12 the midwife asked the man if he would like to cut the umbilical cord. Gordon (No2) and Stephen (No. 12) both did so but the other two refused. I did not see any midwife ask the mother did she want to cut the cord. I asked one of the midwives why she had asked the man and she said it was to include him. It could be considered that the man is symbolically and actually separating the baby from his mother and taking over as a parent. When the baby was born onto the bed or as in the case of Cheryl up onto her abdomen the atmosphere lightened. Both mother and father (and the grandmother if she was there) in all cases except one were both laughing and crying at the same time and it was common for the father to be overcome with tears. The one exception was where Chris's was absolutely delighted but Rita refused to look at the baby at first and shouted, *"Never f... again. I am never having another. I don't want to see him"* ObsNo10. When the second midwife had wiped the baby with a towel Rita eventually looked over to him and was *"overcome with delight. She asks and is given him to hold"* ObsNo10

Birth Rituals

At the moment of birth (apart from one instance in the case of Anne and Gordon who already knew the sex of the baby) the first exclamation in all

cases was to affirm that he was a boy or a girl and so began the process of gender ascription and enculturation. It was usually the father or the mother who exclaimed this. Sometimes it was the midwife and in the case of the forceps and the caesarean births the doctor was the one who made the statement. He or she was almost immediately handed from the first to the second midwife. He or she was then wiped dry by the second midwife and given to the mother. I did not see the mother hold the naked baby for longer than a few minutes and the father not at all. He or she was then taken by midwife number two and labelled and weighed in the labour room on a set of portable scales. This was sometimes accompanied by a little game of guess the weight. S/he was then wrapped in a dry blanket or towel and given to either the mother or the father. The one exception was in the case of the baby born by forceps and he was handed to a paediatrician who put him on a resuscitaire, checked he was in good condition and then handed to the midwife. When this small ceremony was over the second part took place. If the baby was given back to the mother she tended to gaze at and nurse him or her. As the midwife began to deliver the placenta the father was asked to sit down and he was handed the baby to hold. The father then spent a lot of time looking at the baby and commenting on his or her physical appearance. For instance Terry whispered to Alex that *"He is big isn't he"* and tells the baby *"You have had a busy day little fellow"* ObNo13. However the comments were usually more specific in that the father and grandmother (and sometimes the mother) were looking for familiar features and comparing the baby to the other children of the family, other family members or more general family traits. An example of this is when George and Elaine (grandmother) *"both chipped in with information about their other little boy - his weight etc. this baby turns out to weigh less than his brother and not to be as long (7lbs 15ozs and 8lbs 8ozs). The family start to rationalize that accounting for the difference in scales he was probably the same weight."* ObNo3 and *"Elaine and George took turns to hold*

the baby and Elaine started to compare him with family members. She said he had blue eyes like his father 's family but had his mother's family nose. They were talking to him and saying "your grandfather and your brother will be made up" ObNo3. Or again "there are comments about the baby's appearance - his long length and comparisons are made with Terry who tells them he is 6 feet 1 inch, and his huge testes which Terry commented were not like his. There is laughter all round" ObNo13. This type of welcome happened at each birth and was a process of acknowledging the baby as a member of the family. Sometimes this was accompanied by the father walking up and down as Chris's did "beaming with delight and thanking everyone in the room for their help" ObNo10. By the time the baby was half an hour old s/he had been categorised in terms of gender, weight, length, name and family characteristics. This process was continued by every visitor, such as Kirsty's mother ObNo4., who entered the baby's presence.

When the placenta was delivered and the midwife was satisfied with the mother's condition the healthcare assistant brought the couple some tea and they were left alone for a while before the mother and baby were transferred to the post natal ward. During the day the father

Text Box 7.10 Birth, Joy and relaxation.

Stephen is beaming and leaning over Mary kissing her forehead and cheeks.

The baby a girl was born and Gordon started to laugh and cry at the same time. He was hugging Amy and squeezing her

The baby was handed to Chris who walked around the room smiling, nursing and talking to him as the midwives completed the delivery of the placenta .

The baby was born and Tim and Kirsty were delighted and laughing

She gasped as Gordon told her it was a boy. George and Elaine (the grandmother) were in tears as the baby was put onto Helen's abdomen.

Drew looked quietly pleased. He did not speak. Amy lay still, with her eyes close, quietly smiling

The head is born and Ewan looks and smiles with a look of wonder on his face

was allowed to accompany her. In the evening or at night he was sent

home and told to return in the morning, which one man told me later felt was a really lonely feeling *"It was dark, it was late on. There as no-one I could tell"*. p07.

The Third party

The woman in labour was allowed to have her partner and one other person as companions in the labour ward. In four of the labours the woman's mother was present for part of the time and in a fifth the woman's friend was present for the delivery. Overall they did not intrude into the couple's experience. In the case of the friend ObNo12, Stephen and Mary were on their own for nearly all of the time and Patricia the friend stayed in the visitor's room for most of the time. She came in at the delivery and stood behind the midwife on Mary's right hand side. She explained to me that she and Mary were childhood friends and had attended each other's babies' births. She did not touch or hold Mary and was obviously acting as a friendly observer. Stephen was courteous and friendly to her but I did not notice any real conversation between them.

The four grandmothers were also not present for the whole of the time. In two cases ObNos3, & 9 the grandmothers did their best to blend into the background and sat in chairs quite a distance from their daughters. The men were very considerate to them. George ObNo3 in particular kept asking Elaine if she was alright and sometimes dropping a kiss on her head. Similarly David ObNo7 was concerned for his mother in law's welfare and when she had a hypoglycaemic attack he kissed her and went out to make arrangements for her to go home. It is possibly significant that these two men were slightly older than the other two. In each of the other two cases the grandmother seemed at first to be trying to exclude the man. In Ewan's case ObNo9 his mother in law kept trying to take the seat nearest her daughter and rushed to do things for her such as wiping her face before Ewan could do so. He was seemingly unaffected by this and the atmosphere in the room was good. As the labour wore on he sat closer to his wife and gently joked with both her and his mother in law

(June), as he slowly eased June out. She gradually took more and more of a back seat.

Luke's case ObNo5 was quite different. At first he was perched on a stool and looked tired and uncomfortable whilst his partner's mother sat close to her in an armchair. When the midwife asked him whether he had been present at Susan's previous delivery there was an uncomfortable atmosphere as he replied that he had not. Later on he went home and returned later than Susan's mother thought necessary as she made clear by sharp remarks. Outside the midwife commented to me that she thought that the grandmother disliked him as she tried to distance him at every opportunity. Her daughter shouted at her at one point and asked why she had come. She tearfully replied that Susan had telephoned for her. Later on she became more relaxed and eventually spent the latter part of the labour in the visitors room with her other daughter. It is possible that they had had a row and cleared the air or that she had been stressed by seeing her daughter in pain and was projecting it onto Luke. I have no way of knowing because they cancelled the follow up interview.

It seems that the men could be in danger of being excluded to some degree by the presence of the woman's mother but that men ameliorate this situation themselves by their handling of the circumstances. It did not seem to be related to marital status but was more likely to do with social dynamics that prevailed prior to the delivery and birth.

Caesarean Section

Three of the women failed to make progress in labour according to the active management of labour protocols in place. They were transferred from the labour room to the operating theatre within the labour ward. In all three cases they had epidural analgesia 'in situ' and the anaesthetist topped this up and the operation performed under its effects. In each case the men accompanied the woman into the theatre. I was not able to go in with them but could watch the process through a window in the

door. In each case the man sat at the top of the theatre table near the woman's head and was able to talk to her as she was operated on. A screen separated her abdominal area from view. It was obvious that the man's area had shrunk considerably even from the small place he had had in the labour room. His role was also greatly diminished in that he could give verbal support and witness the baby being born but little else. However his being there showed that he had been successful in *alliance formation* and had demonstrated his ability to be a *supportive champion* quite well and was still exercising *protective vigilance* and *becoming a father*. The only aspect of the role that was temporarily suspended was *linkmanship*. The men were undergoing very mixed feelings and emotions as they told me in the follow up interviews.

Conclusion

By examining the texts of the observations and accompanying memos, focus group transcripts, and field notes I was able to arrive at the main 'story line' of the role of the father in the labour room. It appeared that the participants all subscribed to the belief that having a baby is a dangerous and complicated affair during which the woman and the baby are vulnerable and at risk. The doctor is all-powerful and high in the hierarchy. The midwife is less so but acts as an intermediary between the doctor and the woman and her partner. She can help keep things 'normal' and can be a powerful ally for the father. The man cannot know anything first hand experientially but can and does very often understand the process cognitively and being at the labour and birth is also his experience. He is not an observer in the accepted meaning and he is not just a relative. It is his baby and he is undergoing the process of becoming a father. He is made aware that his presence is not a right but is tolerated by the institution and its personnel. He must intuitively know how to form an alliance with the midwife in order to fulfil his role. This is mainly to be protectively vigilant, support and champion his

partner, form a link between the inner world of the labour ward and the outer world of family and friends but most importantly of all to be there when his child is born. This means, among other things, picking up the signals and acting accordingly by not venturing out of his allotted space, being pleasant and unobtrusive, openly supportive but not over demonstrative to his partner, asking the right amount of questions and keeping his relatives in order. Some of the issues and questions I had about the happenings in the labour room were used to form the basis for a semi structured follow up interview with the fathers which will be discussed in the next chapter.

Chapter Eight. Follow up

Introduction

In this chapter I talk about the follow-up interviews with the men and some of the woman which took place in their own homes between eight weeks and three months after the birth of the baby. The interviews were transcribed and analysed using the concepts and categories developed in the previous chapter. I examined the meaning of the behaviours that I had witnessed and asked the men about their emotions and understanding of their role in the labour room. They overarching categories were considered for sufficiency and inclusiveness.

Number in Sample

I attempted to contact the fifteen couples after the birth by sending a letter (appendix seven) to remind them who I was and to let them know that I would be contacting them by telephone the following week to make specific arrangements for me to visit. George and Helen did not have a telephone and I contacted them through a relative. She informed me that she thought they did not want to continue with their participation. This surprised me because they had been extremely co operative and friendly during my fieldwork. Alex informed me that she and Terry had separated immediately after the birth. I was unable to reach Tim and Kirsty, Luke and Susan, and Jill and Kevin by telephone. The numbers I had been given were unobtainable. So I sent the couples (along with George and Helen) each a letter with enclosed stamped addressed cards giving dates for them to choose. The only reply I received was from George and Helen declining to be interviewed. I checked the remainders' addresses through the hospital system and they seemed to be accurate. So I was forced to accept that they did not want to participate. I was not unduly surprised because Kevin had distanced himself quite a lot (including sleeping much

of the time), Tim was quite shy and inarticulate and in the case of Luke and Susan there had been obvious tensions in the labour room.

The Questions

The fieldwork in the labour room enabled me to observe the behaviour of the fathers and their interactions with the women and the health professionals. However there were some aspects that could only be clarified by asking the men about their point of view. For example when they distanced themselves was it because they felt like leaving. The semi structured interview schedule was devised (appendix eight) based on the aspects in Text Box 8.1. Originally I intended to interview the men alone, however when I arrived at the homes in all cases except one the women were present and obviously intended to stay. I did say I was there to interview the men and over all the interviews reflect this. The women's contribution very often enriched and added another dimension to the answers, but I do not know how much they influenced the men's' answers.

*TEXT BOX 8.1. Concepts to
be followed up*

- Reasons for attendance*
- Activity*
- Physical and verbal support*
- Knowledge*
- Team member*
- Observer*
- Emotions and baby joy*
- Distancing*
- Physical*
- Contact/intimacy*

Answers to the Questions

The text box 8.2 gives an overview of the answers to the questions and Table 8.1 gives a visual display of the frequency that some of the concepts were mentioned.

TEXT BOX 8.2 Interviews with Observed Couples
Observations No. 1-14 logged against questions 1-20

Questions **Obs No.1** **Obsv.No.2** **Obsv.No.6** **Obsv.No.7** **Obsv.No.9** **Obsv.No.10** **Obsv. No.11** **Obsv No.12** **Obsv. No.14** **Obsv.No.15**

| | | | | | | | | | | |
|---|--|----------------------------|---|-------------------|------------------------------|--|---|----------------------------------|---|-------------------------------------|
| Was this the first time you have been at a birth? | NO | NO | NO | YES | NO | YES | YES | NO | NO | YES |
| Why did you decide to be present this time? | Natural | He's got a daughter | Natural | Part of 90's | Took it for granted | Once in a lifetime experience | Support for her | Support for her | They're our children and wanted to be par of it | Support for her |
| What are your overall impressions of being at the birth? | Happy & pleased | Nervous & excited | Good experience | Scared, Brilliant | Amazing | Shock Enjoyed it. Over the moon | Tiring & stressful | Messy, bit of a shock | Brilliant experience but didn't feel part of it | Such an important part of your life |
| Did you have any expectations and were they met? | Don't know Hoped everything would be all right & it was | Better than what I thought | Expected it to be better than last time and it was. | None | Expected to be in more rooms | Expected a lot of people there & there was not | Do not know what to expect. Things might go wrong | Did not expect it to be so quick | Did not know what to expect in theatre | Did not know what to expect |

| | | | | | | | | | | |
|--|---|---|--|--|------------------|---|---|---------------------------------------|--|--|
| Did you feel in control and could you stand up and move about? | Not clear answer | Not clear spoke about going in and out of labour ward | I didn't know if I, I would ever feel it was my place to be in control, if you know what I mean. Need to be involved and respected | Felt left out | Yeah, Yeah | Until she started in pain and then I could not move about | No you're never in control of that thing. When the action starts you are pushed to one side | Yeah. Well not through the door. | I was up and down everywhere | Not specific |
| Were you free to come and go as you please? | Did feel constrained to being in the room | Oh yeah thought it was brilliant | It's a bit of a hassle you know you've got to press the buzzer and wait and say to somebody. | If Joanne had said go out I would have gone out. | Yeah, Yeah | I could move around freely | Erm No. I think it was. Yeah you could come and go as you pleased | Oh don't feel you can go out of there | No it was just a case of sitting there waiting and that's what we did. | Not appropriate |
| How were you supportive to .. when she was in labour? | Just to know I'm there | Yeah. I did at the end .Like in the day I was just wiping your face | Yeah, I think so. | Just being there | Just being there | Just being there, helping her | Gave moral support | Just hold her hand. Say push | I tried my best to be supportive and calm her down and help her | We were just holding hands all the way through |
| Did you have enough knowledge and information to be useful? | No | No | Yes I think so. | No | Not really | It just came naturally | No not really | Oh yeah | I don't know | No not at all. Books in the labour room |

| | | | | | | | | | | |
|---|--|---|--|------------------------------------|---|---|---|---|---|---|
| How would you describe your relationship with the midwives? | Very good, absolutely great | Some were good one had no patience | They'd explain to me what was happening | A good help. Telling me everything | All right. They were all right to me/. Alright | A good relationship I'd say, like you'd known her ages | Erm Brilliant! But there was one midwife who erm, not that she annoyed me but, she really like put a damper on the end of the evening | Er, I don't think you have one do you? | Great | The labour ward staff was fine but the (theatre staff). Their handling of human beings was very hardened. |
| How would you describe your relationship with the doctors? | I didn't speak to the doctors much | They only come in at the end | They more come in and communicate with the midwives than with..... | The doctors were fine | We never seen a doctor | No relationship | I can't remember like but they were good | They just breeze in and out. They have no time for you. | They were talking to us and laughing and joking | The people we had contact with, actually conversed with were really nice. |
| Did you feel like an observer or watcher? | No not really no. I felt more part of it | No, not at all. No. I never felt like I was out of things at all. | No | Well not really | No I thought I was being useful | You feel a bit of an observer 'cos you can't really do much can you 'cos they're doing all the work | Yeah, yeah It's hard to explain. Yeah you'd, I think you find yourself gelling into the team. | No | No. At the time it felt brilliant | No I felt really close to, probably as close as when we conceived her if anything I think |

| | | | | | | | | | | |
|---|---|-----------------------------------|--|--------------------|---------------------|--|--|--------------------------------------|--------------------------------|---|
| How did you feel when..was in labour and at the birth? | Apprehensive. Hoped everything would be all right | Stressful | A bit annoyed(wit h doctor) Frightened (when epidural did not work) | I don't know | Me? Made up | . Scared a bit. Oh I can't explain it's just a mad feeling when it's born. | Wary, A bit frightened | A bit scary | A bit nervous | I wouldn't say frightened but it was a strange experience. Pleasurable as well. |
| Did you find anything embarrassing or frightening and if so how did you deal with it? | Nothing at all | I didn't give it a second thought | No, no, not, certainly not, maybe with, with erm, J because it was traumatic. | No | No | Nothing embarrassing, No | Well when. I think when the doctor came in to, 'cos you had to have an internal, but erm, I mean I wouldn't, I wouldn't say I was embarrassed to be there but its I think it was.... | I didn't find it embarrassing. No | No Not for me. | No, not all. |
| Did you ever feel like leaving? | No, no, not at all. No. I did after the first one after about twelve hours | No | Not so much as you want to be somewhere else, as you just don't want this to be happening. | No. No. | No, not really, no. | No never thought | No, I wouldn't, no I left of my own accord anyway, it was just like the doctor needed to do his bit. | Not specific | No. No. No. I mean I wouldn't. | No |
| Were you able to have as much privacy as you needed? | Erm, Yeah | Yeah, Oh Yeah | I think we did | Yeah, it was great | Not specific | Yeah, Yeah | Oh gosh yeah We did yeah | Yeah | Yeah | Not specific |

| | | | | | | | | | | |
|---|--|---|---|--|--|--|---|--|--|--|
| Were you able to have as much physical contact as you would have liked? | Yeah | Yeah. Oh Aye Yeah | Oh yeah, yeah | Oh yeah, yeah | Not specific | If I wanted to yeah | Oh yeah | I think we'd had enough physical contact. Er. | Yes, 'cos there was only us | Not specific |
| How would you sum up the role of the father in the labour room? | Basically support and share when the baby is born | A supporting role To be included | A supporting role but more because it's your child that is being born and you're the father | To be there for her and to support her | Just to see her through it I was there for her | Just help making sure she was all right and making her feel better | An important role to have, you know to hold, to have yeah to feel secure and to be supportive | Baggage carrier aren't you really, bag handler, nappy carrier. No I don't know you just. | To support your partner | It's a tough one this |
| What do men need to fulfil this role? | I don't know. Knowledge would be helpful but going in blind sort of helps. | Parent classes | Not specific | Time off work after the birth | It depends on the man really. Some of them might (need something) Others like myself, I was all right about it | I don't know you just have to have a, with me its just a good relationship | A good relationship | I think the only thing a bit more technical for blokes | All you can do is be there for them and do the best you can, I mean, there's nobody that should know your partner better than you. | I think they need to know, there's going to be what feels like an hour's wait (outside the theatre) prior to er, |

| | | | | | | | | | | |
|---|--------------------------|--|---|--|--------------|--|--------------------------------------|---|--|--------------|
| How as the experience affected your relationship if at all? | Puts perspective on life | I think it brings you closer for a while after, but I think once that, once you start getting your sleepless all that, that's forgotten about isn't it really? | Oh, no. Just as it was before we had any children | I'd say yeah (brought closer) and no. On certain things like. Yeah | Not specific | I don't know you just have to have a, with me its just a good relationship. If you've got a good relationship it's easier. | It hasn't affected it at all has it? | It wasn't nice to see all the blood and... But er not the actual relationship | No it's not changed. Nothing has changed These children are the icing on the cake. | Not specific |
|---|--------------------------|--|---|--|--------------|--|--------------------------------------|---|--|--------------|

TABLE NO. 8.1 Numerical Overview of Fathers' Answers to Follow up Semi- structured Questionnaire

| | | |
|-------------------------------|---|---|
| Q1 | Was this the first time you were present at a birth? | |
| Yes | | 4 |
| No | | 6 |
| Q2 | Why did you decide to be present this time? | |
| Natural | | 3 |
| Present previously | | 1 |
| Modern thing to do | | 1 |
| Once in a lifetime experience | | 1 |
| Support for her | | 3 |
| To be included | | 1 |
| Q3 | What are your overall impressions of being at the birth? | |
| Positive emotions | | 3 |
| Negative emotions | | 3 |
| Mixed emotions | | 4 |
| Reflective | | 1 |
| Q4 | Did you have any expectations and if so were they met? | |
| None | | 1 |
| Better than I thought | | 5 |
| Did not know | | 4 |
| Q5 | Did you feel in control in the labour room? | |
| Not clearly answered | | 5 |
| Don't know | | 1 |
| Felt left out | | 1 |
| Yes | | 1 |
| No | | 2 |
| Q6 | Were you free to come and go as you please? | |
| Yes | | 4 |
| No | | 3 |
| Not clearly answered | | 3 |
| Q7 | How were you supportive to your wife/partner when she was in labour? | |
| Just being there | | 5 |
| Physical care & contact | | 2 |
| Moral support | | 1 |
| Verbal support | | 1 |
| Calming influence | | 1 |
| Q8 | Did you feel you had enough knowledge to be useful? | |
| Yes | | 3 |
| No | | 6 |
| Don't know | | 1 |
| Q9 | How would you describe your relationship with the midwives? | |
| Good | | 6 |
| Mixed feelings | | 3 |
| You don't have one | | 1 |

| | | |
|--------------------------|--|--|
| Q10 | How would you describe your relationship with the doctors? | |
| Good | 4 | |
| No relationship | 6 | |
| Q11 | Did you feel like an observer or watchful? | |
| Yes | 1 | |
| No | 9 | |
| Q12 | How did you feel when your wife/partner was in labour? | |
| Apprehensive/scared | 5 | |
| Annoyed | 1 | |
| I don't know | 1 | |
| Mixed emotions | 2 | |
| Happy | 1 | |
| Q13 | Did you find anything embarrassing? | |
| Yes | 1 | |
| No | 9 | |
| Q14 | Did you ever feel like leaving? | |
| No | 9 | |
| Not specific | 1 | |
| Q15 | Were you able to have as much privacy as you needed? | |
| Yes | 8 | |
| Not specific | 2 | |
| Q16 | Were you able to have as much physical contact as you would have liked? | |
| Yes | 7 | |
| Not specific | 3 | |
| Q17 | Did anyone support you during this time? | |
| Mum &/or dad in hospital | 2 | |
| Nobody | 6 | |
| Family at home | 2 | |
| Q18 | How would you sum up the role of the father in the labour room? | |
| Support | 4 | |
| To be included | 1 | |
| To be there for her | 3 | |
| Not sure | 2 | |
| Q19 | What do men need to fulfil this role? | |
| Don't know | 2 | |
| Parentcraft classes | 1 | |
| Time off work afterwards | 1 | |
| Knowledge | 2 | |
| A good relationship | 3 | |
| Q20 | Has this experience affected your relationship at all? | |
| Reflective answer | 1 | |
| No | 4 | |
| Brought closer | 2 | |
| Not specific | 1 | |

Of the ten couples that I interviewed the father had been present at a birth before in six cases and for four men it was their first experience. Nine of them said they wanted to be there and that there had been little discussion about it. It came across as the natural thing to do. Only one man seemed to have reservations and indicated that after the first baby he would really rather have not gone into the labour room but considered that if he hadn't he would have "let everyone down" especially his wife. He said to her in the interview that she would have been "gutted, wouldn't you really if I hadn't have gone? Be honest. You'd be devastated if I wasn't there. Unless I was working away and I couldn't get back. Something like that" po12

One man mentioned the presence of a social expectation who considered that it's "all part of the '90,s you know"po2 .

Apart from it being the unspoken and 'normal' thing to do the men spoke of wanting both to support her and to have the experience for as Paul said

"they're well they're our children and I wanted to be a part of that. I wanted to experience it as well. I mean, plus, she has done all the work for nine months. I mean I've done nothing, that's all. That's all. I mean she's done everything and people are

TEXT BOX 8.3
Post delivery interview

Question No.2
Why did you decide to be present this time?

No.1

It was just a natural thing to do really.

No.2

I was just going to be there and that was it

No.6

No I mean I wanted to be there anyway, and I mean Alison wanted me to be there, and I don't know it just seemed the natural thing to do really I never asked. Just wanted to be there

No.10

You have to go in anyway, that's what it was

No.14

Because at the end of the day they're our children and I wanted to be part of that. I wanted to experience it as well

No.15

Erm I felt you have got to support, I had to support Fay. I couldn't let her go in on her own and I was intrigued to see how it all worked.

congratulating me now. I keep saying 'I've done nothing, you know, congratulate her not me' My work is just starting now, helping for, helping for bringing them up. So if I could help her a little bit through it then I was going to be there for it and that's all" *po14*

Themes from the Interviews

| TEXT BOX 8.4 . New concepts introduced by the fathers | |
|---|------------------------|
| Concepts | Core Category |
| Having the authority to decide Relationship building with midwives Relationship building with doctors | } Alliance Formation |
| Embarrassed Time –Length of labour Excited Information from midwives | } Protective Vigilance |
| Role of father | } Becoming a Father |
| The following concepts were not mentioned at all by fathers <ul style="list-style-type: none"> ❖ Active position, ❖ Birth- relaxation ❖ Birth –rituals, Invisible –compliant ❖ Midwife’s thoughts/judgements. | |

I analysed the transcripts of the interviews using the same method as before (Strauss & Corbin 1990). When I inspected the resultant concepts I found that the men did not mention five of the original concepts. These were, *active position*, *Birth-relaxation*, *Birth-rituals*, *Invisible-compliant* and *midwife’s thoughts/judgements*. However they did expand on *emotions* by talking about their *annoyance*, *boredom*, *excitement*, how they had felt *panicky* and how they had been *put off*. They (and their partners) talked

about family as visitors, information from midwives, the labour -epidural, the labour -pain and privacy. The concept of relationship was expanded to include the relationship of the man with the doctors and the midwives and to include how the new baby affected the couple's relationship. They also discussed the role of the father and a new concept of Time - length of labour was added.

Alliance Formation

Relationship Building

The men all talked at length about their relationship with the midwives even though Stephen started off by saying "Er, I don't think you have one do you?"¹². Generally, when the men spoke about the midwives it was to praise them as the following excerpt typifies,

No 06 Audrey and Neil Relationship Building: With Midwives

"I thought they were very professional and they gave you, you know they appeared very professional and caring without being intrusive, so it felt like they were for you practically and everything, and, and were really caring while at the same time it felt quite private experience, as well. It was, interesting how those two things could go together really."

The midwives were described as being "absolutely great, friendly, helpful"¹¹, they were great to me ¹⁷. They were alright.¹⁸ The relationship was very important to the men and their partners. The labour room was an emotionally charged atmosphere and although the midwives were being professionally friendly and chatty the couples invested the relationship with a great deal of emotion. One of the men talked movingly about a particular midwife and commented that he and his wife would like to continue the relationship on a social level. Much later I spoke about this in general terms to the midwife concerned and she did not reciprocate the feeling¹⁹. The midwives were seen to be a crucial factor in whether the experience was viewed positively or not as Chris's says below.

No 10 Rita & Chris Relationship building: With Midwives

"A good relationship I'd say, like you'd know her ages. Like we'd only been with her three hours and it's like you've known her for a few years."

However reservations were expressed. Mary thought, *"the younger ones were always nicer"*^{p012} which Stephen put down to the older midwives a *"lack of enthusiasm"*^{p012}. One couple considered that a midwife that they did not like had attended the woman at least for part of the time. The reason for their antipathy was because the midwife was interpreting the situation, exerting her authority and imposing her own value system on the events.

No 11 Cheryl and David Relationship building: With Midwives

- C *I didn't like her myself*
D *Erm, because, once the baby was born, was it when the baby was born, or when he was like, half his head out or something like that?*
C *Yeah well that was a strange thing really, because, I asked for a photo, do you know when the baby's head is just emerging and they ask you, do you want to put your hand down and feel? That totally frightens the life out of me, I don't know why, but I swore all through, 'cos I regretted it with my first two, not doing it, you know just feeling before the baby was born and really regretted it, and I said all the way through this one, if I don't have the bottle to feel this time, I want a photograph for my own personal use, just to, see what I could have felt, and when David was going to take a photograph, she said, she just wasn't happy with that at all, she said no! you know, move, move, move. Your wife doesn't want that. I was like but I do, it's my request, you know.*

Another woman expressed her dislike for the midwife on the morning shift but liked the midwife who had looked after later on and subsequently delivered her,

No 02 Anne & Gordon Relationship building: With Midwives

Well. I remember all of,- the one I had when I went in, and the one who I ended up with in the end. She was all right the one in the end. She was horrible to me in the morning, which makes it worse, 'cos, it's like, when I go for a smear I'll, like that, if someone's nice with me it makes you feel totally different doesn't it, and she wasn't,

James^{PO15} thought that the midwives on the postnatal ward *"were second rate"* and *"their handling of human beings was very hardened"*. However his wife rationalised this by saying that it was she who had exaggerated the problem because *"you're feeling quite emotional at that time"* but they both agreed that the *"the labour ward was fine, all the staff, up to me having Jennifer were brilliant"* ^{PO15}. The conversations made it quite clear that the formation of an alliance with the midwife was an important if not a decisive aspect of the perception of the labour for both the father and the woman in labour. They knew it was crucial to the woman being allowed some freedom of choice as the previous extracts make clear. However what was not discussed was the fact that the man could have been asked to leave by the midwives.

The men were quite aware that they were not on the doctors' list of priorities as can be seen by the comments below.

Relationship with doctors

No 01 Sally & Jack

"Erm, I didn't really speak to the doctors much. Erm, ? they only came in sort of, erm, they only really came in ? I was mostly the midwives most of the time you know that I saw, I didn't really speak to the doctors "

No 02 Anne & Gordon

"They only came in right at the end, deliver. The doctor came at the end, but I was up the other end of the table then, so I had er, I shook hands with them at the end and that, er but that was basically it."

No 06 Audrey & Neil

"I think some of it is, the doctors role is that they've got to be find out what's going on, and what they need to do, and then they go on to the next case. A doctor come in, a b c d and this is, it wasn't, it's not so much more a caring thing as a, as a come in fix this make a decision, practical, bang, bang, bang, and then go on to the next one, kind of thing."

No 07 Joan & Derek

"The doctors were fine like, but I'd say the midwives done the majority, cos they're, the end of the day the doctor comes and we'll do this we'll do that, and the midwives have got to do everything through, coming to see the doctors."

No 11 Cheryl & David

"Erm, the same, I mean, I think we seen about two doctors like but they, I can't remember like, but erm, they were good."

No 12 Stephen & Mary

"Personally, do you want to know what I think, I think they just breeze in and breeze out don't they? No time for you and that's only the, the erm, the one when you were ? No I just think they just come straight in and rush out. But there's nothing, if there's nothing there by that time, unless you have trouble, you know I think, there's nothing much to say really is there, bar is he normal you know, healthy."

No 14 Stella & Paul

"The doctor was in and out. Or a paediatrician, I don't know, I'm not sure what he was, you know he was in and out all the time, but they did, they did, they just took over"

No15 Fay & James

"The only one who we really spoke to was the anaesthetist who just told me, you know, about the anaesthetic other than that."

R *"So the doctors didn't talk to you? "*

F *"No. They did say congratulations at the end. They did say that."*

This did not seem to bother them too much because the doctors were seen as technicians whose job it was to come in when called to a problem, fix it and go away again. The men did not need to form alliances with them because they considered the person with the responsibility was the midwife as Derek said in observation No 7 (Table 12.4). Or as Neil explained they were not the ones who were the carers, they were the fixers.

Being a person and telling his story

The men did not seem to be aware that they had told the midwives their story or things about themselves. This was not mentioned to me although some did tell me all about their experience at previous births for example Gordon^{P02} who told me about the bad forceps delivery of his previous daughter or Jack ^{P01} who spoke about the caesarean section his wife had with their first baby.

Compliance

They did not say at all that they had actively been compliant although they mentioned a lot that they had been sitting down for much of the time and one man reminded me that *"erm, you're always in the background but you're always there"* ^{P01}. They were also acutely aware that although they could move about in the labour room they were not free to come and go as they pleased. This was not seen as being too onerous for as Gordon said,

"I felt that was more of a nuisance rather than a, you know when they ask you to lock the doors, I think that 's a great idea that, keeping the doors locked, but I felt I was more of a nuisance, you know going out and that, and having to like let them, get the nurses to let me back in" ^{P02}.

However the power differential was recognised even if it was not overt as Derek showed when he said, *"As I say, you couldn't just, you'd have to say 'I'm going for a paper, or 'I'm going for a walk'. You couldn't just, you couldn't have just,"* ^{P07}. Or as Stephen commented *"You feel you can only*

stop in that room, but the rooms were very big." p012. Stephen considered that,

"you don't feel as if you can wander round and er, you feel a bit like er, with all this security as well. Steal a baby! You think people are looking at you, in that respect you know. 'Who's he', you know. I just stopped in the room, or in the hallway really but I had to". p012.

The power of the institution forced them to conform.

Consequences of not forming an alliance

None of the men mentioned to me that they could be asked to leave. The only time the midwife was mentioned as being in authority as when Gordon p02 talked about being made to leave his wife (in his opinion) too soon after the birth.

The fathers did not mention that they had been laughing and joking with the midwives. Joking was only mentioned in relation to caesarean section when Paul said that the doctors were laughing and joking as the baby was being lifted from out of Stella's abdomen. If Douglas (1999) is right when she tells us that the joke has a subversive effect then in this situation the doctors who were familiar with the procedure were possibly trying to normalise or defuse it for Paul and Stella whose dominant idea or emotion would likely to be that of fear.

Protective Vigilance

Observation

The men's comments supported my observations that although they were quiet they were not passive. All but one of the men were positive that they were not observers. Being an observer was likened to being excluded, an outsider and not part of the event. Watching is what other people did from outside the situation. This meaning was shared by all of the men who mentioned it in one form or another. Jack clarified his point of view by explaining that when *"you're observing you're in the background and you're looking you know, whereas, it's yours you know, and it's part of you. So it's you know not really observing. No."* p01. Nearly

all the men (see Text Box 8.2) repeated this in various ways. James clarified his position by saying that *"I felt really close to (Fay), probably as close as when we conceived her if anything I think"* p013. Gordon immediately assumed that to be an observer was to be an outsider. As he said when asked did he feel like an observer, *"No, not all no! I never felt like I was out of things at all"* p02. Chris's thought that he wasn't an observer but after a moment's reflection he described his feeling of not being able to do much and so acknowledged that

"You feel a like a bit of an observer. 'Cos you can't, you can't really do much, can you? 'Cos they're doing all the work, all you can do is hold her hand and support her really I suppose."

The only man who immediately said he felt like an outsider was Stephen who had also said he would rather not have been at the latest birth. He said,

You're only a bystander at the end of the day aren't you? You are! I mean I'm not... I think women like men to be there so they can see how much it hurts as well. Well you do. Don't you? I mean that 's your feelings" p012

Whilst 'observing' was related to exclusion, the men did talk about their watchfulness. They were watching the midwives and the doctors to make sure everything was all right and sometimes to remind them to do something. As Neil said,

"There were odd occasions when I'd say 'Is that, is that right? And they'd say 'Oh yeah. I suppose we should, you know do that'. Probably not anything in particular significance, sometimes just that watchfulness, is, maybe mostly just give yourself peace of mind" p06

Others echoed this theme of watching to ensure everything was being done properly. Derek said he was watching the anaesthetist inserting the epidural needle and was thinking *"that you've heard of other people*

who've had it and they say they've suffered with back pain in years to come, something like that." P07. Stephen spoke about *"watching, making sure they're doing everything all right"* P012. He did acknowledge that although he was doing this he had limited knowledge and was only making sure from his perspective *"that's all I was doing, making sure, well what you think, well you don't know do you? Just making sure that you think that."* P012

Time

The monitoring of time was a constant feature of the vigilance procedure. Nobody said they had any knowledge of what is considered by the midwives to be the normal time parameters of labour. However each of the men and the women talked at various length about the time the woman started in labour, when they arrived at the labour ward. They were also concerned with the length of time they were there, the length of time it took to have the baby and how long it was before they were given the baby. The labour ward is a strange place with its own time rhythms based upon shift changes and length of labours. It was evident that the men were managing the situation in terms of their own understanding of the length of labour. I had noticed that that the midwives had not given them factual information about the progress of labour but this was not commented on at all in the interviews. They did however say that time seemed to go a lot slower than they expected especially when they felt stressed such as when the midwife was examining the baby. The short period before she said everything was okay could seem like ages. Knowledge of time and its management is part of the normal control of one's life and in this case the men in particular demonstrated that they were organising it in their minds even if they were not given information about it from the health professionals.

Face watching

When I observed the men watching their partner's faces intently I had interpreted this as watching for signs of pain and distress. Only one man

mentioned watching his wife's face in this way and he put another perspective on it. He said he was watching for mood swings.

"So you've got to like watch her all the time and mood swings are unbelievable. Because if you took it to heart whatever she called you or something like that, you know, you would. It was, just like, in one ear and out the other, for now, her saying. When you look back, do you remember what you called me, and it's funny. Hmm" P07

Knowledge and Information seeking behaviour

The men talked at length about the previous knowledge or lack of it. Six of the men thought they did not have enough information to be useful, three of them thought they did have enough and one did not know. Of the four first time fathers, three said they did not know enough and one said he had sufficient knowledge because *"it just came naturally."* P010. However it became clear that he meant he was able to encourage Rita to push the baby out. Only two couple had ever been to parentcraft classes. Sally and Jack had gone in the first pregnancy but only for two weeks because the birth was premature. Gordon and Anne were the only couple to attend in the current pregnancies. The reasons put forward for not going were inconvenience of timing, apparent irrelevance, lack of awareness and embarrassment. Gordon was very enthusiastic about the parentcraft classes because as he said he enjoyed it and *"It's the only way you learn isn't it?"* However he seemingly contradicted himself by also saying he thought it put him off because he did,

"not know what to expect" and "you see all this off the telly, people screaming and everything, and while we were going to those classes it's right beneath the delivery suite isn't it? So we heard people screaming, and everyone's faces was white wasn't it? P02

The midwives were seen as a good source of information and the comment was made several times P02, P07, P06, P010, P013. that the midwives

"explained everything"^{p02}. Yet I had observed very little information seeking behaviour. David explained this by saying that he thought that the midwives were doing a job and *"you've got to stay out of the way a bit like. It's their (midwives) knowledge and that sort of stuff, not that, why should I, you know involve myself in that sort of stuff. I mean"*. ^{p011}. The only person who had reservations was James who thought that there should have been information books and leaflets in the labour room itself.

Distancing

Although I had observed all the men distancing themselves both physically and by averting their gaze not one of them admitted to either feeling like leaving or being embarrassed. Jack was quite surprised to be asked the question because as he said *"in the end the reason you're there is to see the baby being born"* ^{p0}. It is possible that they did not realise they were doing this and that it was a way of being protective and vigilant and yet respectful of the woman's dignity. The only men who did say that they left at all was Stephen who said that he used to sneak off for a smoke in a previous labour but now as a non smoker he stayed in the room. Derek talked about leaving the room *"when the doctor needed to do his bit"* and hinted that it enabled Joan to ask intimate questions. He explained it by saying that,

"Joan wasn't all there anyway like, so at last she didn't know I was gone or anything, so I like just got off, you know what I mean, gave me a, you know, a little five minute break while somebody else was with her anyway, and then Joan could have, you know what I mean, then just came back like when, the doctor left like so."^{p07}.

Supportive Championship

Supporter as fan

Although I observed the men giving verbal support in the labour rooms when it came to the discussion afterwards very few of them really talked about the verbal support they had given. The common theme was about

being there for her and giving moral support (see examples below). Even though David, for example, knew he had talked Cheryl through it he didn't really know what he had said to her. What he did remember was that he had pushed with her.

"I mean you're getting involved and you're getting, you're like getting, you're dead, you know, light headed and everything like, so you know you're there for her and, you know what I mean, and you're pushing with her like. But I don't know why you push, but you do, you just, going like that with her." P07

The women confirmed that the moral and verbal support was appreciated. As Cheryl said *"He kept me strong. He kept me going really"*. P08. Stella echoed this when she talked about having her caesarean section. She said that there was no way she could have *"laid there with all those people around me, even though they were so good and not have anyone to, like, support me"*.

TEXT BOX 8.5 Moral and Verbal Support

- No 1. *I was always there for Sally.*
- No 2 *Just telling you to go to sleep*
- No 6 *Physically and verbally supportive.*
- No7 *Being there for her, giving moral support*
- No 9 *Just being there I think.*
- No 10 *Talking her through it.*
- No 11 *Just to say to her 'Ah. You know. Are you alright'?*
- No 12 *Saying push. Yeah.*
- No14 *Just leaving me to calm her down.*

Supporting part
The men had mixed feelings about their supporting part. On the whole they did not talk about the tasks that I had seen them doing for the midwife. However they expressed mixed feelings about both being included and feeling left out. They seemed to feel included until matters deviated from the normal or when the baby was about to be born. Neil typifies

it when he says; *"I didn't feel like I was ignored. Erm I mean I didn't have*

like, kind of er, an involvement in that I did things, or cut cords or things." P06 Derek *"felt a bit left out because as I say everyone's doing their own jobs aren't they?"* P07. David felt *"You're just pushed to the side"* P011 whilst Stephen said, *"You are treated as little bit as though you're, you know, they're very good with you, but, you're just there as extra baggage aren't you really?"* P012 and James *"did feel that little bit excluded"* P015

Support giver

Although I had witnessed tender moments between the couples and in particular eye contact only five of the men actually spoke about this aspect of their time in the labour room. Paul talked about looking at Stella and *"luckily she kept looking at me"* P014 and *"holding her hand and stroking her forehead"* P014 but he was the only one who mentioned the eye contact that I had seen a lot. Chris's mentioned that he hadn't hugged Rita but thought she wouldn't have wanted to be hugged anyway *"all the pain she was in."* P010. James said to Fay that he was *"holding your hand all through it"* P015. The other two made a joke of it. Derek said he thought he had been rubbing his wife's hand but when he looked down it was the student midwife's hand. He said, *"I was saying you are going to be alright and the student midwife Helen said 'I know I am' and it was so funny because I had hold of them. I was rubbing her hand."* P07. Stephen commented dryly that they did not need to be holding hands because he thought they had already had enough physical contact.

The others did speak a little about the care they gave such as *"washing her head"* P02 or *"holding her leg up"* P010 or offering an *"arm for squeezing"* P011. Eight of them did say that they had enough privacy. Ewan P09 and James P015 were not very specific on this point.

Nurturing

Although I had witnessed nurturing behaviour in the labour room only one of the couple's mentioned it when Chris's P010 spoke about giving Rita sips of water to drink. The only time food was mentioned was by Anne and Gordon when they talked about the amount of sweets and chocolate

they had consumed whilst staying in the evenings during the pregnancy. Perhaps it was not mentioned precisely because it was a social act of inclusion between the two and seemingly trivial in the light of the major life changing events surrounding them.

Championship

This was another aspect of the labour that I had witnessed but which neither the men nor the women mentioned when I interviewed them later. Although the women spoke to me about their labours and the feelings that they had experienced they did not mention that their partners had acted as advocates for them nor did they during the telling imply that they felt in need of one. The nearest thing to this was when Gordon acted in this manner in the interview when Anne turned to him for confirmation that she was terrified of needles and he confirmed it saying *"yeah she really gets, she works herself up."* po2

Linkmanship

All except Jack and Stephen talked about their linking role in that they mentioned that they had been or tried to be in touch with relatives throughout the labour. Stephen said he had rung but nobody was there. Jack said he hadn't rung them from the hospital although they had taken their little boy round to Sally's mother on the way in. Jack implied that this was because he wanted to be there on his own with Sally. This was based on the experience of the previous birth when Sally's mother, *"was there for James, and after a while you think, 'I wish they'd go home' You know you don't really want anyone there, 'cos they, you don't really."* po1. Although the rest of the men said that they were in communication with their families or friends for most of them this was mostly a linking and information sharing activity. They told them how the women were progressing in labour and in return received information about the wellbeing of their other children and messages of support for their partner. When the baby was born they announced the news to as many

people as they could. Derek described how he had used up all his money in the hospital ringing round and when he went home he,

"was on my phone. I must have run up a bill, looked at my phone bill and looked it all up." I was even ringing in the ASDA. 'Guess what? She's had a baby boy and all that.'...The likes of work, rang into work and the boss was there, and he said. "Right what did she have?"he wrote it on the notice board for all the lads in work." po7

Six of the men thought they had been given no support from families or friends whilst the other four were very enthusiastic about the way they had been looked after. Six of the couples were first time parents and although one of the women was in labour for the first time her partner was experiencing it for the second time. The other three couples all had children together. The support was in the form of asking if they (the men) were alright, if they needed money or it was of a nurturing kind. For example when Gordon's mother came up to the hospital with *"a big bag of goodies, and give me like, a tenner, so I could get some tea."* Of the four men who said that they had received support from their family only one Derek_{po7} had had his mother in law present in the labour room. Of the other interviewees only Ewan's mother in law had been present. I had noted that he had gently asserted himself in the labour room and she had gradually moved away. He did not comment about her in any way but when I asked did anyone support him whilst Amy was in labour he answered *"No, Myself"* _{po9} and when I asked him if he had needed anybody he replied that he hadn't. He was the only person who had actually said he did not need support. The others seemed to correlate support with the families being physically present. They then gave reasons why they were unable to be there for example Paul _{po14} who said that both families lived too far away or James _{po15} who said that they just wanted the two of them to be present.

Becoming a Father

Emotions

The two main emotions of the experience for the fathers were fear and joy. All the fathers described the feeling of being scared or frightened throughout the labour. This was exacerbated at times of obvious problem such as the fetal heart decelerations which had caused the doctors to decide to take the three women for caesarean section or when epidural analgesia was being inserted. But the men spoke about having a constant level of fear even when this was down-sized to “*apprehension*” or “*nervousness*.” These emotions were common to all of the men (see Text Box 8.2) and the tenseness that I had noticed in my observations were variously described as being worried, wary, having an inner panic and feeling helpless. They were very aware that the natural process of labour can be fraught with danger and that although the midwives and doctors were knowledgeable they also knew that things could go wrong. Stephen who had noticed that there was blood in the anaesthetist’s syringe exemplified this. Following this the anaesthetist had asked Mary could she feel her legs and Mary said that Stephen turned white at this question. Stephen confirmed that on hearing this he felt terrified and thought that the anaesthetist had paralyzed Mary.

The fathers found that seeing their babies born was a very emotional experience. Although with one or two exceptions they were not an articulate group of people they did express their joy in their own way. The main feeling was of joy. This was variously described as being “*made up, happy, the proud father, just in tears*” and “*over the moon*” (See text Box 8.2). The experience was described as being unlike anything they had ever experienced before and this feeling was not confined to the first time fathers. Each man said words to that effect. These feelings were captured by Jack when he said “*I think it, I think it, erm, puts perspective on life when it’s, when you see a baby being born, you know, erm, I don’t think there’s anything better in the world, that.*” Or as James reflected,

"All these things come along and you think are important and they're nothing compared with birthing a child" P015. Or again Paul who said, "I was present at the birth of my kids which I am really thrilled I was there....I just stood and watched her being born and that was brilliant, that was a brilliant experience" P014.

The other main feeling was that of sharing the moment. It was recognized as a life changing experience, which they felt, was something they had needed to share. For Paul it was about seeing *"new life come into the world, and it was brilliant, a thing we share, that experience was absolutely brilliant" P014.* As Jack reflected *"its about sharing the moment rather than coming in an hour later and saying, er, here's your baby. At least, like, you can look back in ten, fifteen years time and you were there."*

P01

Rituals

They did not talk about the rituals as such and only occasionally talked about the moments just after birth in other than emotional terms. Nobody talked about the experience of cutting the cord or examining the baby for family characteristics. Both James and Paul mentioned that it seemed to take a long time between the baby being born by caesarean section and being given to them to hold. Neil described how he was surprised and shocked at seeing the midwife towel dry his baby in what he considered a rough manner. *" 'Cos to me it just looked like, you know when a dog's been in, in the pond or something, and you get a towel and you go like that. And I thought, 'what are they doing to my baby?' You know" P06.* This observation dismayed me because I had seen this happen and knew that because the baby was a little slow in commencing respiration, the midwife was actually stimulating the baby to breathe. The baby had responded to the stimulus and cried lustily. None of the midwives, myself included, had considered how this action might look to Neil. This is an instance of the 'knowing' professional being so immersed

in the matter of fact aspect of the care that she or he are blind to the alternative meanings that can be ascribed by the 'unknowing' relative.

The Role of the Father

Of the ten men interviewed eight of them summed up the role of the father as that of being a supporter to his partner. James^{P015} was as he put it for once stuck for words and couldn't really answer. Stephen^{P012} was quite ambivalent. He at first thought he was there to be a *"baggage carrier"* but then qualified it by saying; *"No I don't know you just, I think you have to be there"*. However he then went on to say if the normal practice was for men not to go in then it wouldn't have bothered him. The others tried to grasp the essence of what the role meant to them and struggled to express it. They constantly used the word support and refined it as physical, verbal and moral. This support meant that they were as Derek put it prepared *"for anything she wanted me to do"*. For him it was also a moral obligation and his responsibility because he had *"put her there in that position"* and he felt sorry for women who were on their own. When he reflected and looked back on the experience and *"think about other people, the lads who are not with the girls, and you say to them that's tight. What are they going to do, they've got no one to support them?"*^{P07}. In this he echoed views expressed by men in the pre observation interviews and showed that he thought that the supporting role was an important one. Ewan who was the least articulate of the ten summed it up concisely as being there to *"just see her through it. If she wanted me or anything. I was there for her."*^{P09}. This theme of seeing her through it and being there for her reinforced the idea of the woman undergoing a rite of passage, which was painful, strange and dangerous. Although they did not have a great deal of knowledge the men were the woman's watchful guardian and assistant. Jack ^{P01} actually verbalized this when he said that he thought the role was *"being an assistant, being, erm, erm, being a guide and help really, you know"*. He also thought he wouldn't *"want a woman to do it on her own."* The concept of the man as

an assistant was actually quite different from that in the literature. Whereas this considered the man to be an assistant of the midwife, the men thought they were there to assist the woman. It was also very clear to me that the issue of the father being there was not about alleviating loneliness. It was about being an actual help in an ordeal as well as to be there as a father and to share the moment of birth.

Knowledge Required

Only one man thought that parentcraft classes would be helpful in undertaking the role. This was Gordon^{PO2} who had attended a whole series. However he did not like the venue which was just under the labour ward and thought the breathing exercises were a "*waste of time.*" The most important aspects to him were, the information giving sessions and the personality of the midwife who delivered the classes. Anne described her as "*lovely*" and by him as "*great*". None of the other men considered them to be important. For them the two main requirements were, some technical and factual knowledge about the processes and the equipment, and the strength of the relationship between the couple. It followed on from their understanding of the role as being 'there for her' that the most important requirement was a knowledge of the woman. The health professionals tend to fragment pregnancy, labour and the puerperium into separate entities with their own associated knowledge but the men did not see it like this. They were in a relationship and it was this that was important. Although they had acknowledged that birth was a new a very different experience for them, in some ways they did not need to gain new knowledge because they 'knew' their partner in all its meanings and in the knowing came the understanding of her needs. The midwives were acknowledged as being the experts in the process but they, the men, were the experts in the emotional care as the following extract shows.

"I think just instinct, that, I mean, a lot of it is instinct, you know what I mean 'cos not that you've been with someone for a length of time but it's, you know, you know how to like, approach, you know your wife, your girlfriend, you already know what, what annoys her, what doesn't annoy her, what she needs, 'cos I mean all the way through the pregnancy, I mean the hormones are kicking in, you know different things, you know what I mean. So I think, I think you've had enough, you know what I mean, you can have as much as you can, like, you know what I mean, so, the last hurdle, you know what I mean. It's just like, I wouldn't say you just walk through it, but you know, you're prepared for anything, so"

PO11

Subsequent relationship.

When asked about the subsequent effect if any on the relationship two men did not specifically answer the question and started to talk about their children. All the others were adamant at first that it had either not affected the relationship at all or it had brought them closer. However on further thought two couples acknowledged that having a sleepless baby, or toddlers coming into the bed did disrupt their closeness somewhat. Gordon talked about sleeping on the couch in an effort to get some sleep. However both couples did not think this indicated a problem with the relationship.

Paul said that the children had not affected the relationship at all because what they had could not be improved upon,

"As far as it comes, as far as it is between us, this is, these two are the icing on the cake as far as me and Stella, well as far as I'm concerned with me and Stella. I've always wanted children and the fact that we've got them is brilliant. Er, I don't, they couldn't improve what we've, I don't feel they could improve on what me and Stella have got. They could only, like I say, they could just, they are the icing, they are the icing on the cake. The finishing touch!" PO14

Conclusion

The categories identified in the observation schedule were found to be sufficient and inclusive in the analysis of the interviews. The men were very clear that their role was to protect and be vigilant on behalf of the woman. What I had observed as distancing was firmly discounted as wishing to remove them from the situation. Instead it was part of the protection in that they were protecting the woman's dignity. They considered that they were there for two reasons, which were, to support their partner and to be part of the birth of their child. Supportive championship was extremely important and so they had to be and to feel included. Although they did not consciously talk about forming an alliance with the midwife they did talk at length about how important having a good relationship was to them and to their partners. The doctors were recognised as being important but in some ways were considered peripheral to the event. They talked about being the link between family and friends and the woman in the labour room. Although they did not openly say that they knew their position in the labour room was fragile they did tell about feeling uncomfortable when entering and leaving the labour room.

Being at the birth was spoken about as the most emotional and transforming event of their lives and was truly becoming a father, which for all of them seemed to be a most wonderful experience.

Chapter Nine. Reflections

Introduction

In this the final chapter I consider the strengths and limitations of my study, and I reflect upon the methodology and how some of its aspects it might, in retrospect and with hindsight, have been improved. I then revisit the research questions and show my findings about them. I describe how I generated the categories that I used and tell the story line of the theory generated during the research work. The role of the father is reflected upon particularly in the light of Foucault's work on power relations and struggles within Institutions. Finally I consider the implications for practice, which lead me to make recommendations for future research in this area.

Reflections on the Process

Preliminary Interviews and the Quantitative Questionnaires

The preliminary interviewees were recruited opportunistically and the numbers were small. Although I developed a list of open questions from a rigorous search of the literature, there is always a possibility that my own views coloured my selection of the issues. However it is difficult to see how I could have overcome this. I did ask a colleague to look at the questions prior to the interviews. Perhaps I could have sent them out to a larger group of professional peers for validation. It is also possible that the people I interviewed were atypical in their views. However this is something that cannot be overcome with a qualitative approach and a small accessible sample and does not render the data meaningless. The voices of these participants are the ones that are heard. I was extremely keen to be methodical in my approach and had another person check my line-by-line conceptual analysis. We agreed over the phrases and words selected but at times differed in the names for some concepts. This does not detract from the findings because as modern day writers on

qualitative methods such as Denzin (1989) argue there is no one empirical truth waiting to be found and so a plurality of meanings can be explored.

The data from the quantitative questionnaires were limited by five factors, namely the: -

- a) origin of the questions,
- b) sample size,
- c) response rate,
- d) type of respondent and finally:
- e) accuracy of the tool.

I have described how the questionnaire items originated. It is possible that I missed something relevant and important. However it is also possible that I did not since, in the event, few people put forward anything new on the comments page,

The hospital had approximately 6000 births per year and as a rough rule of thumb there would be about 5000 births eligible to be included in my study. I roughly estimated that only 4000 of these births would be in a couple situation. So my choice of two hundred couples represented a sample of approximately 5%. There were approximately 100 midwives who were eligible to be in the study and I considered 50% to be a reasonable sample size. All the doctors were included. On reflection the estimate seemed adequate although perhaps I could have used all the available midwives.

I had to rely on midwives giving out some of the questionnaires out and I cannot be sure that they always did so. Another limitation was that I did not have time to attend the outlying clinics myself. The response rate was reasonable for a postal return but limited the analysis. I could, for example have given out all the questionnaires directly to respondents and waited for those who completed it (I received the completed forms back over a rather long period and people may have meant to return them but forgotten to do so. I also used the University's free post service, which

returns to a central point. I had a worry that I did not always receive those that had come back to the University.

I sent the questionnaires out separately with separate return envelopes but often I received two in one envelope, obviously from a couple. It is highly likely that they consulted each other on their answers. The return from the doctors was very small numerically although statistically it represented 30% of their number. It is possible that I received replies only from those doctors who were particularly interested.

Although I asked the midwives to give them out on a *first come, first served* basis it is possible that some midwives may have given them to 'nice' couples whom they thought might be more likely to complete them. If this was so it would have introduced a certain amount of bias.

I tested the tool on several midwife colleagues in the first instance to ascertain face validity i.e. to find and correct any obvious flaws in the design. After refinement I piloted the questionnaire with approximately 10% of the proposed recipients for content validity. It is possible that even after this there were inaccuracies in the structure or format of the tool.

Ethnographic Study

The argument regarding the purported limitations of ethnographic studies in general have been detailed in chapter two. Briefly the positivist argument is that the data can be contaminated by the subjectivity of the researcher and are not scientifically objective enough. I hold to the alternative view that it is impossible to obtain 'uncontaminated' data in social settings where the interactions are essentially symbolic and where the actors do not have set response to stimuli. I work from a basis of existential fact (Hammersley and Atkinson 1991) and have obtained the data from the world as I observed it from my own cultural, personal and professional viewpoint. However I have attempted to be rigorous and reflexive in my observation and analysis as I detail later in this chapter.

By using an ethnographic approach, which I detail in chapters ten and eleven, I was able to analyse and interpret the meaning of the interactions I observed. One of the apparent weaknesses of my sampling procedure, that of opportunism, could, in fact, be regarded as a strength. Because I was not able to recruit the observed couples prior to the labour I did not recruit from a particular group or stratum of society (see Table 7.1). All the men were white, Susan and Amy were black and there were no representatives from other ethnic groups. They were typical in most respects of the everyday clientele of the labour ward, except perhaps that the midwives had identified them as being 'nice'. However I was grateful of this very basic screening as I approached their homes for my post delivery interview sessions.

Post Birth Interviews

The major limitation of the post delivery interviews was accessing the people. I lost one third of the sample (five couples) even though only two refused to see me. On reflection I would have been better conducting an initial interview in the hospital prior to the woman being transferred home. In this way I would have had the opportunity to talk to the fathers who seemed to have the most problems in the room (Tim, Luke and Kevin). It is possible that they might have been more receptive in the hospital. Also I realised one dark evening as I approached a block of flats in a run down part of town that I was, in fact, rather vulnerable. As it happens in the event all the interviewees were couples (except one father) and were warm, welcoming and non-threatening. (One couple even posted a young relative to guard my car).

Another limitation was that I used a schedule of open-ended questions that had arisen from the observations. These produced rich data but I was conscious of sticking (albeit loosely) to the questions and it may have produce even richer data if I had not used any structure at all.

Reliability and Validity

I have described in chapter three how qualitative researchers try to ensure validity and reliability in their work. I have tried to do the same and be trustworthy, credible and dependable by using the four criteria of confirmability, auditability, authenticity and fittingness (chapter two).

I have tried to describe the research process in sufficient detail and quoted extracts from the transcripts to give a confirmable, auditable and authentic account of the route I have taken. I visited and revisited the data both by hand and using a computer package in order to display and link condensed typical and atypical extracts. I used a range of data collection methods (interview, observation, focus group and questionnaire) to inform on the same phenomena. Also I collected data from a range of participants. So there was triangulation of methods and sources. I considered the possibility of other conclusions and verified them where possible, for example by asking the fathers at the post-birth interview for explanations. I also searched the literature in order to find an existing theoretical framework that would explain events.

I was aware at all times that I am a midwife and consciously try to look at the events and the context of the labour ward and labour rooms as if I was a stranger. It is possible that I did not always succeed but I made strenuous efforts to stand back and become an observer rather than a midwife participant.

'Fittingness' is difficult to assess but I have used several methods including a questionnaire to a larger number of people. The data have been looked at closely in various ways and interpreted through the progress of coding to identify the theoretical framework of the overarching categories and the story line

Reflections on the Research

There were very few observational studies of interactions in the labour ward with the notable exceptions of Kirkham's (1983) study of information and support giving, her consideration of the basic supportive

care in labour (Kirkham 1987) and Perkins (1980) study of men on the labour ward. During the period of my study Hunt and Symonds (1995) published their ethnography of the working practices of midwives in the labour ward of two hospitals. However my study was different in that it focused primarily on the role of the father in the labour ward. Draper (1997) was also at the time reviewing the literature on the trend of fathers' birth attendance, as a preliminary to her longitudinal, ethnographic study of men's experiences of pregnancy and birth but she did not directly observe fathers in the labour ward. Vehviläinen-Julkunen, K. & Liukkonen, A. (1998) were also interviewing men following the delivery in order to gain an understanding of their experiences in the labour ward.

Reflections on Role Theory

According to Linton (1936) a status is a position an individual has in a particular pattern of reciprocal behaviour between individuals or groups of individuals i.e. it is a collection of rights and duties. Role on the other hand is the dynamic aspect of status. When an individual tries to effect his or her rights and duties he or she is playing their role.

The role can either be ascribed to one by others without one having any ability and can to some extent be predicted. An example of this is caste membership. Or the status can be open to competition as in a job vacancy and it achieved as a result of one's own efforts. Linton (1936) considered that people acted one role for each of the statuses they occupied. It seems that he thought the majority of roles in society were ascribed thus enabling a lengthy training period and reducing the need for sporadic and unpredictable role filling by achievement. This is useful in times of set social patterns but in the presence of change such as the relatively recent entry of fathers into the labour ward, new patterns of behaviour are required.

Merton (1957) Observed that there were people contingent upon the status that had the potential to interact with and influence the person in a variety of ways of behaving. These ideas were taken up and developed various perspective, the most well known of which are functional, symbolic interactionist, structural, organisational and cognitive role theory. I do not intend to address these perspectives in this work but merely mention them to put the following in context.

Role theory according to Raffel (1999 p11) *'starts from the idea of a requirement or obligations that impinge on all those who occupy a position'*. To play the role competently as Raffel points out in his analysis *'would seem to demand just mechanical compliance with expectations as one's actual social task'* (Raffel 1999 p3). It could be argued that the social expectations are to be internalised and become one's own. This is not as simple as it would appear for as Merton (1969) pointed out there is disorder as well as order within social structures. He put this down in part to role conflict i.e. the stress on the individual resulting from the differing demands and expectations of people that s/he has to deal with as part of the role. These other people were termed members of the role-set. According to him (Merton 1969 p 425-28) the individual works out which of the role-set members is maintaining the demand most consistently or who has the most power in the hierarchy and conforms to that expectation. Using this model it is clear that the members of the fathers' role-set are their partners, the doctors, the midwives and the family members. The people with the most power in the labour ward seem to be in descending order the doctors, the midwives and their partners. This suggests that the role of the father in the labour ward will be prescribed by the doctors. In this case the competent father in the labour ward will overall conform to their requirements. This simplistic view does not take into account the person as an individual but as Goffman (1974) and Zimmerman & Weider (1974) pointed out the

experience of the individual in society is more multi dimensional than this model would have one believe. For example outside of the labour ward it is perhaps their partners that men need to take more heed of in the long term. Although there are role expectations that may be in the form of power manifest as rules and policies it is part of the individual's experience to identify the contingencies and interpret the role. According to Goffman (1974) the actor does by distancing his 'self' from the role whilst Zimmerman & Weider (1974) consider that the actor needs to be active and to negotiate, interpret and create the role. This fits with Foucault's assertion that power relations are always in a state of fluidity, resistance and negotiation. Hilbert (1981) in his explanation of an ethnomethodological approach summarises role behaviour as acting on the assumed intentions as well as the obvious role expectations. Mead goes slightly further in that he considers the individual to not only interpret the expectations of the role-set but to be able to become an object to oneself and to take on the attitude of the 'other' (Mead 1952 p138). This has echoes of Foucauldian thinking in that the actor can be considered to become subject and object and is the overseer of the role and its interpreted behaviour and so becomes at the same time competent and committed yet resistor and negotiator

Expectations of the father

This was one of the identified subsidiary aims which was to examine,

Fathers', mothers' and health professionals' expectations of the role of fathers in the labour room.

In the literature review I noted that MacMillan (1994) said that men wished to be with their partners in labour. This was borne out by the findings from my interviews (although the men felt that they were frequently under pressure from their partners to be there). It was almost the social norm for fathers to be present. Everyone including the health professionals seemingly accepted their presence regardless of the type of

labour or delivery the woman was experiencing. However there were issues of power and control, which meant that although men were tolerated in the labour ward they still have no absolute right to be there.

I found that the literature had identified five role expectations (see chapter two) of the father, which in effect were really only a list of behavioural objectives ascribed to the role. These were to,

- enhance the positive experience of the labouring woman,
- provide (mainly emotional) support,
- fill the gaps left by busy staff,
- act as an advocate and ;
- be a subordinate, well-behaved member of the team to control the mother.

Enhancing the Positive Experience of the Labouring Woman

My study supported these aspects to a greater or lesser degree. The social and emotional support function was the one that seemed to be uppermost in the participants' minds. I explained that the fathers thought they were '*there for her*' but they were also there for themselves, a point that rarely cropped up in the literature. Both sexes had taken on board the gender ascription and its expected behaviours. This led to belief systems about support and the effectiveness of men as supporters. I explored the knowledge base of men and found it to be resourced through various channels of information such as '*young dads' tales*' as well as more formal channels such as books and magazines. The men thought they would be '*looking out*' for their partners and their support role was that of protector. This cropped up many times in the interviews and was supported by the questionnaire results. However, in our conversations, the women tended to hold two, simultaneous but contradictory, expectations of the men. On the one hand they considered them to be weak individuals who were frightened of hospitals and blood and who would most likely themselves to be in need of support and protection. Yet on the other they were also unanimous in thinking that

the men would be, or had been, supportive and protective. They also expected the men to 'behave well' i.e. to conform and give them no cause for shame. The groups were unanimous in rating the role of the father as that of giving encouragement to the woman, helping her through the experience, helping to reinforce breathing exercises, making her feel safe, validating her experience, and having shared memories. They also considered it important for the man to be an advocate for the woman although I found the context, working practices and power structures militated against this happening in practice. Instead the context in the form of symbols, rules and use of space gave out the powerful message that fathers' presence was tolerated only if they were passive and compliant.

Providing (Mainly Emotional) Support

On first examination there would seem to be a tension between the expectations of the midwife in relation to the support role of the midwife and that of the father and as I showed in chapter four there was ambiguity in the midwifery models in regard to woman-centred care provision. However on further analysis it became clear to me that the midwives recognised that the father did have a support function and the problems melted away to some extent when the concept of the father's support was distinguished from the midwife's. His was considered to give social and loving support with its own rules of behaviour whilst the midwife's was to give a more professional type with its own separate and distinct behaviours. The doctors were not considered by any groups to be support givers. Because there was a most definite and dominant medical model of treatment (rather than care), there was no conflict apparent in the doctors' performance of their role and their communication patterns.

Gap Filling

There was a discrepancy between the expectations of the midwives and that of the fathers in respect to the function of gap filling. Because the men considered that the support of the women was their function and

that they were there to see their own babies being born they did not expect to be there as gap fillers for the midwives. It appeared that they thought of it as being the other way about i.e. the midwives were the gap fillers for them. So when the midwife entered the room the man could if he so wished leave his partner in safe hands whilst he went out for a while. In doing so he was expressing some autonomy in that the choice to leave and re-enter the room was under his control.

Acting as an Advocate

There was an expectation from all the health professionals that the father would be an advocate for the woman although as I say in chapter five this was sometimes correlated with being troublesome. In practice I rarely observed fathers being advocates in the sense of speaking at length on the women's behalf but I did find them to confirm and defend women's statements and positions.

Being a Subordinate, Well Behaved Member of the Team.

Although they were obviously subordinate in the hierarchy and most definitely had to be well behaved, as I explored in the context, power and birthing room chapters it was not overtly expressed by the midwives that the fathers were there to help control the women. The doctors did however articulate it in relation to the fathers' helping with procedures. Overall the midwives rarely rated the fathers' assistance to both midwives and doctors as important so perhaps they did agree with Summersgill (1993) and think that the fathers were being given 'pretend roles'. New fathers disagreed with this and thought that their assistance was sometimes important however I think they saw this in terms of being useful to the midwife or doctor rather than being a controller of their partners in labour.

Role Performance

This was articulated as the second and third sub aims, which were to,

Observe the interactions between the fathers, mothers, and health professionals in the labour ward.

And

Identify the role performance exhibited by the fathers in the labour room e.g. coach, passive observer or assistant to the midwife.

Behaviour in Context

In this study I found (as did Oakley [1986]) that all the participants tended to be actors in a drama. Although the details of each script varied the main theme and the roles that people took were similar. The context was that of a 'production' site with the fetus as the product and quality control on behalf of the state as the function of the health professionals. There was a gradient of power with the health professionals being at a higher level than the fathers and mothers. The doctors' and midwives' power was derived from their professional knowledge and status and their behaviour was inextricably linked to this, although the midwives tended to move between two frames of behaviour, the medical and the lay (Peräkylä 1989). The fetus as 'product' was the focus of the 'gaze' and the policies and protocols and other performance indicators of the labour ward were designed to ensure a high quality process was used to bring order out of chaos. I showed how the fathers (and the mothers) had to realise very quickly that they (the fathers) were not there as of right but were only tolerated by the Institution and its personnel. Although fathers are recognised as being verbally abusive on very few occasions and are (rarely if ever) physically abusive, tight restrictions were placed on the presence of the father and other visitors, the underlying assumption being that they might otherwise get out of control.

The Role Performance Exhibited by the Fathers

I found that all fathers exhibited similar types of behaviour to one another, which did include some of the three aspects (coach, teammate and witness) as described by Chapman (1991). However I considered them to be quite variable. The fathers in my study rarely acted as coaches and although they did at times act as teammates in that they responded to requests for physical and emotional support, I did not find

them to be passive witnesses. Instead I found that they were more actively engaged in the process. I was able to describe their behaviour using concepts such as relationship building, distancing, face watching, nurturing, birth joy and invisibility. By following Strauss and Corbin's (1990) method of axial coding, coding and re-coding, grouping and regrouping I developed five overarching core categories into which I was able to fit all the concepts and which formed the story line or theoretical construct. Following the post delivery interviews I re-examined the data, concepts and categories and found them to be sufficient and inclusive.

The Overarching Categories

The five overarching, core categories are, alliance formation, protective vigilance, supportive championship, linkmanship and becoming a father which form the story line.

Alliance Formation

The father at admission to the labour ward is aware or quickly becomes aware that he is an 'invisible' person with little or no power to remain. In order to reduce or prevent exclusion he needs to ascertain the rules of behaviour and comply with them. One of the key factors is the necessity to form an alliance with the midwife who although not as powerful as the doctor is a key person in keeping birth normal and in tolerating his presence. He attempts to do this by demonstrating that he not a threat, is compliant but is, nevertheless, a person in his own right. A range of strategies is used including passive body language, keeping to his allotted space, and being pleasant, smiling and joking. The consequences of not forming an alliance can range from exclusionary body language from the midwife to actual ejection from the labour ward.

Protective Vigilance

Whilst the man is quiet he is not actually passive. He is being protectively vigilant in that he is alert and watching the midwives, the doctors and his partner. This vigilance includes watching his partner's face and monitoring her for signs of pain and distress. Occasionally a father attempted to look for a sight of the head before the midwife thought it

proper. It seems to be unacceptable to some midwives for him to look at his partner's genitalia unless the baby's head is just about to be born. This may in part be due to an attempt to desexualise the context particularly in the light of the modern metaphor of birth as orgasm (Walton 1994). He exhibits distancing at times to protect himself from difficult situations and also to protect his partner from undue exposure.

Supportive Championship

In addition to protective vigilance there is the supportive championship aspect where the father exhibits various types of support functions such as advocacy, nurturing and intimate contact. Other aspects include being a supporter (or fan) who gives encouragement and moral support, having a supporting part by doing little jobs such as passing the Entonox mouthpiece to the woman. He is also a support giver in physical ways such as helping with the pain and discomfort by lifting the woman, back rubbing, holding and rocking her. Physical intimacy is desexualised by the lack of privacy and is restricted to eye contact, arm and leg rubbing and brief kissing. Likewise nurturing behaviour is restricted and regulated.

Linkmanship

The man acts as a linkman or communication channel between the secluded area of the labour room and the family life. This serves three functions. The first is to act as a link between the woman in labour and her family. He passes words of encouragement to her and gives information to the family and friends. It is also a support function for himself. The family and friends give him moral support and in some cases food and money. His third function is to act as an overseer of the visitors' behaviour. If they become loud or unruly it is his responsibility to maintain order and if necessary to require them to leave.

Becoming a Father.

The final category is that of becoming a father. It is obvious that the actual birth is an emotional experience. This is when the man usually stands up, watches the birth intensely and becomes joyful when the baby

is born. Certain birth rituals seem to be common. They are part of the process of enculturation as the baby is moved from its wet, bloody and naked state to being a dry, weighed, measured and dressed little human being. During this brief period, the father and other members of the family, if present, ritually accept him or her into the family by a process of open acknowledgement of family physical characteristics and by comparing the baby with existing siblings.

Power

So far the story line of men acting in a particular way in the labour ward describes their role with its ascribed behaviours and to some extent their position in the hierarchy. It seems that men are fulfilling the role with little if any role conflict. It is tempting to leave it there but to do so would be to tell an incomplete story. What needs to be considered is the question of what is really going on and why. It is easy to think that the State's power is transmitted in a simple and monolithic fashion downwards through the institution but as Foucault (Dreyfus And Rabinow 1983) points out there are numerous, inter linking networks of power relations at play. This is true of any institution but is particularly so in one as strongly regulated as a hospital. There is a tension between the professional groups and in order to maintain their power the health professionals utilise a series of strategies as I described in chapter six. These serve to maintain the hierarchy and individuals' positions within it. At the centre of care (or arguably the bottom of the order) are the women and their partners. The practices in the labour ward are such that their effect is to reduce the woman to the status of a child.

In Western cultures *"the metaphor of the child provides one important vehicle for and structure within which human dependency of whatever kind is understood"* (Hockey & James 1993). This concept is so ingrained into people's thinking that it is considered 'natural' rather than historical and cultural. Because of this a whole series of social practices have been

developed around the care of the child as a being in need of protection and incapable of decision making. In this model the competent and responsible adult acts on behalf of, and in the best interests of the child. As several writers have pointed out (Kirkham (1983, 1987, Walton 1993, Edwards 1998) the language used by the midwives in particular is 'baby talk' and this was observed again in this fieldwork. It could perhaps be argued that this might be part of the everyday dialogue in the North of England. Having said that when one considers this in conjunction with practices such as sedation, restriction of space and movement and the limitation of information, in combination with a strange and overpowering environment then it is not too far fetched to say that the process is one of infantilization. Although there is probably no deliberate intent, the effect of these practices is to encourage further dependency and a stripping away of adulthood along with its two features of autonomy and independence. As both Kitzinger (1989) and Davies-Floyd (1992) have alluded to, the woman can be likened to an initiate in a 'rite of passage' (Turner 1990, Van Gennep 1909/60) where she goes through the three phases of separation, liminality, and reintegration. During this period she is ritually and symbolically fenced in from danger and taken through the ordeal by a 'wise one' (who has usually been through the ordeal). The order of birth and death is reversed in a rite of passage and one "*dies to become a little child*" (Turner 1990 p. 273) and a state of liminality exists where the woman is in the middle ground between categories of social life. In this stage the person is surrounded by symbols signifying danger that needs control from the authority of the elders (the midwives and doctors). On the other side she is reintegrated into society with a different and usually higher status. One of the key features (Turner 1990) is that as the initiate moves through the 'rite' is usually in the company of others in the same situation. This in turn leads to what he calls 'communitas' a "*community of feeling that is tied to neither blood nor locality*" (Turner 1990 p201).. When women gave birth at home as I described in chapter one

they were often in the company of other women. Although these women did not fit the scenario exactly because they were past rather than current initiates, it is likely that a form of *communitas* was in play. Now with the move to birth in hospital the scene is quite different. The woman is more isolated and accompanied in the main by her partner who has no embodied experiential knowledge. Because the metaphor of the child is so deeply rooted in practice it seems natural and unproblematic as the basis of care delivery. The midwives and doctors with their symbols and artefacts of power act in a 'caring' manner and on a personal level would most likely be shocked to think that their practices are damaging. That this is so is eloquently argued by Hockey and James (1993) who point out that the baby talk in particular is *"a key logical cognitive structure through which human dependency is created and re-created in Western cultures."* (page 13).

As I showed in chapter four the men and women are socialised into the belief that birth is dangerous before they enter the institution. However they think that the father is there to support her and *'be there for her'*. This they tried to do as I showed in chapters seven and eight. Nevertheless the forces that militated against them were immense. 'Baby talk' was not used to them but they were disempowered in other ways. This as I discussed earlier was achieved by separation and confinement within a hostile environment, the use of restrictions on space and knowledge and marginalisation as a person. They were separated from their normal everyday lives, from their time management skills, from their relatives and peers and from their autonomy as adult men. This served to reduce their sense of worth and self esteem as was evident when more than one man said he felt like *"a spare part"*. Two things seemed to be happening to them, they were being marginalized and they were being made invisible or as Edwards (1998) described it, screened out. Marginals according to Turner (1990 p233) are people who simultaneously belong to more than one social group whose *"social definitions and cultural norms*

are distinct from, and often even opposed to, one another. Fathers in the labour room very obviously fitted this description. This was particularly apparent in their linkmanship role when they moved physically between two roles. In one they had power as an adult male about to become a father and in the other they were dependent, vulnerable and as Kirkham (1987) noted dispensable. Their strategies for overcoming or reducing this were first of all to comply with the overt and subliminal requirements of the institution. Men were more or less successful in this due to their ability or not to read the signs, their maturity and skill in dealing with people and their reaction to stressful situations. The more able were active and negotiating, in Hilbert (1981) terms they were acting on assumed intentions and were creating their own role which reduced role conflict and role stress. The less able or less mature were possibly more likely to react in a childish way with a display of temper which would only serve to increase their vulnerability and dispensability and sense of role conflict and role stress. It was evident that familiarity with a hospital environment and nursing/midwifery personnel was an advantage in maintaining a position of alliance. These were the men who demonstrated very quickly that they would comply. They were then the monitors of themselves and in Foucauldian terms both subject and object and according to role theory they were both competent and committed to the role expectations of the powerful health professionals. It was interesting to note that the midwives had observed (chapter seven) that when the women could not trust them to do this for example when they were drunk then they were left at home. I found two other things quite noticeable in this study. One was that the men did not attempt to form an alliance with the doctors. This may have been due to class and educational differences but did highlight the men's different perceptions of doctors as being different from midwives. Or it may have been that they had recognised the seat of labour ward power and were totally competent at meeting the role expectations ascribed to them. The second, was the fact that the

midwife gatekeepers did not hesitate to allow me to gain access to a nurse in labour. Yet on another occasion when a doctor was in labour I was told that one of the perks of "*being in the trade*"^{fn4}, was to have privacy. This included being shielded from the ministrations of a student midwife. This served to reinforce to me that the midwives themselves were both subject and object in the guardianship of the hierarchy.

Screened Out

Edwards (1998) in her work on social support from the perspective of community health and social service noticed a phenomenon that she called screening out. Men were considered to be useful in that they were potentially helpful to workers in that they could take the advice of the workers and follow instructions, they could reinforce instructions given to their partners and they could provide their partners with the extra support they needed. In effect they were acting on behalf of the worker and were "*perceived in other words, as filling a gap*" (Edwards 1998 page 265). This fitted in with the rationale provided by Kierse et al (1995) for their presence in the labour ward. It also fitted with the idea of the midwife as being 'with woman' and providing woman centred care. As a gap-filling substitute for the midwife the father's needs and personal life changing event could be ignored. Screening out made them invisible as people and was disempowering. It made them appear to be solely the docile bodies that accept disciplinary effects as Foucault (1991) shows in his simplification of how hegemonic social arrangements are maintained.

Power Shifts and Power Struggles

In this study the fathers showed a great deal of compliance with the status quo i.e. the dominance of the doctors and midwives whilst supporting their partners and meeting their expectations as best they could. If, as is likely considering the trend towards hospital confinement that was described in chapter one, the majority of births continue to take

place in hospital, then the fathers' presence will become a true social norm with an identified role. This will carry with it responsibilities, duties, obligations and social expectations. At the moment as I have shown the expectations are imbalanced in that the health professionals hold a great deal of power with the women, their partners and their families holding very little. For the women the power imbalance can only be affected greatly outside the particular hospital setting because inside the women are 'as a child' albeit only temporarily. On the other hand it could be argued that the women having submitted to a loss of social power and position have a form of sacred power which enables them to return to the normal social world empowered (Turner 1990 p241). However as women's groups and organisations become increasingly successful in gaining a woman-centred approach to care in childbirth then the balance will shift. Women's expectations will become more ascendant and their requirements will have a stronger pull for the fathers. This will be in harmony with the fathers' belief that they are there for their partners and it could enable them to fulfil the expectations of their partners, their families and themselves in respect to protective vigilance, supportive championship and linkmanship. It may however cause greater role conflict for the fathers in the short term in that they would have to be more challenging. The knowledge of health professionals informs and supports their power, but fathers have another knowledge i.e. they know their partners. If men do not disagree with the expectations of the health professionals as dominant role-set members, then not only are they complying, they are also allying themselves with the power structure and not even seeing the oppression.

It may also be that if their presence at birth becomes a social norm then it will not only carry responsibilities etc. but also power for the fathers. This will inevitably mean that there will be a power struggle because as Foucault (1983 p. 211) points out power struggles are immediate in that they are struggles when *'people criticize instances of power that are closest*

to them' and *'they are struggles which question the status of the individual'*. He considers they are struggles that are in *'opposition to the effects of power which are linked with knowledge, competence and qualification: struggles against the privileges of knowledge'* (Foucault 1983 p 212). Another supporting idea for an emergent power struggle is that of Turner (1990 p 233) who says of marginals that *'sometimes they become radical critics'*. Another consideration is that the fathers' belief that they are also at the birth for themselves as well as for their partners may carry implications for the structure of clinical practice. If they are there as of right it would be much harder for them to be excluded, pushed in a corner and ignored. They would be in a position to make demands as male adult members of society with all that such a position implies. This would include having disruptive power. At the moment the fathers are usually only disruptive at a local and individual level and as I showed the structure and policies of the Institution are firmly in place to minimize this and to exclude disruptive men. This would be more difficult if men were to organise into fathers' groups and seek to acquire rights in the birth of their children. Currently these rights are very embryonic and seem to start only after the birth itself, which I observed with the men returning to their position as an adult male when performing the rituals associated with becoming a father. As I discovered on interviewing the couples after birth this was rarely commented upon because it was 'normal'.

The Way Forward

If a power struggle takes place and the conclusion is a power sharing between health professionals and fathers then women may or may not be disadvantaged. The government is moving towards shifting the balance of power and *"enhancing the involvement of patients"* (DOH 2001b) and *"giving patients more influence over the way the NHS works"* (DOH 2000). It could be that the fathers as well as mothers take some of this power,

become more involved and in this way become more subject than object. If so it throws up some questions e.g. what would that mean for women in labour? Would men look out for women more? Would there be an increase in their advocacy role? How would the exclusionary policies change? Would there be free access to women in labour? Would fathers be the gatekeepers? Would fathers take a more central role in the actual delivery? What would this mean? Would fathers become more aggressively protective? Would the women have to protect the fathers more, or less? Would the fathers demand food, comfort and information? Would the care move from being woman centred to couple centred? There is a possibility that women could find themselves even more objectified and disempowered than at present particularly if they have abusive partners.

It is possible to become depressed at the possibilities as do Crouch & Manderson (1993) in their assertion that woman's power *'has been channelled in various ways by others attending to her when in labour'*, and *'that over time male presence has been given increasing status and emphasis.'* However it is worth considering two factors. These are that Foucault's theory of power according to McNay (1992 p38) sees it *'as a productive and positive force rather than a purely negative, repressive entity, and, a social reality of discourse or amalgam of material practices and knowledge.'* The second factor is that I found in my study that men thought they were there to protect, look out for, nurture, champion, communicate with, give physical care to and overall support the women. Taking these material practices and amalgamating them with fathers' knowledge of their partners it is possible to be hopeful that the increasing presence of fathers in the labour rooms can only be good for women overall.

In order to increase their ability to help women in labour some issues of practice need to be considered. These are:

Communication and understanding

In the hustle and bustle of a busy labour ward it is easy for the doctors and midwives to concentrate on the working practices and try to ensure a smooth throughput. They can forget that the lives and status of the men, woman and family members are being altered and changed forever by the birth of the baby. By understanding the process or story line of becoming a father in a modern British hospital the health professionals can use it to consider the needs of the father as a supporter to the woman in labour. There is a greater need for more openness, appropriate and informative interaction and a development of strategies to effect change in communication and policies to the benefit of the women and their partners. In order to undertake the protective vigilance aspect of their role, the fathers need appropriate, realistic and adequate information regarding the progress and course of labour, especially at examinations and in relation to the entrances and exits of midwives and other staff. They also need to be included as part of the event as much as possible, as equal and valid participants.

If the health professionals are, or become, aware of the power differentials at work between the fathers and mothers and themselves as a group it may be possible to reduce it or some of the effects. They need to be aware of the powerful effects of symbols such as uniforms, notices and the panopticon structure of the labour ward itself. There is a need for awareness of the heightened emotions of the couples and the various ways these are manifest. There is also the need to heighten their awareness that the birth is the father's experience as well as the mother's and that he is not just an observer at an event. It is a momentous occasion and as one man told me (chapter eight) *"they're well our children and I wanted to be part of that. I wanted to experience it as well."*^{po14}. Fathers should be seen as an integral part of the birthing process in their own right. Ongoing professional development in communication and interpersonal skills are to be recommended, particularly for doctors.

The literature (chapter one) shows that an important part of feeling supported and in control is to perceive that one's needs are met. In order for the father to meet the woman's needs it is likely that he requires the following help,

Knowledge

It should be acknowledged that in the couples with a pre existing relationship then the man will have knowledge of his partner and health professionals can work with them to ensure this is used in practice for the benefit of the women. Men's needs for subject knowledge are variable but suggestions the fathers made to me include, leaflets and videos specifically designed to give an overview of the process and to answer men's questions. Videos could be on loan to take home for men who are not able or willing to attend classes. They might also be made available in the labour ward along with labour-specific, and health education leaflets. Classes could aim to produce a more detailed programme to assuage men's fears of being embarrassed, and to ensure that they can be involved in the whole programme, but have at least one men only session (ideally presented by a man). In this study only the midwives thought the content of antenatal classes was inadequate but the majority of the parents were first-time parents and so had little to measure against. Presenters of classes should bear in mind that many men are already fathers and ascertain and try to meet the learning needs, as well as providing a set schedule of topics. They should also try not to appear patronising or screen men out. Part of the fathers' support function is that of acting as an advocate and men perhaps require some information on coping with stressful situations. They also need more information on labour pain and how to help their partners cope with it.

Support for The Supporter

The men are at the labour to '*be there for her*' and need to know how to support their partners and to be encouraged to do so. They need privacy

to give physical support and they need to know how to give verbal and moral support that will satisfy the woman's expectations. Perhaps discussion sessions in antenatal classes could build on this. Support groups for men could be set up, ideally by men themselves or perhaps as an offshoot of existing groups such as the National Childbirth trust (N.C.T) or as local-hospital attached groups.

Fathers are very often on the labour ward for long periods and I would recommend that the facilities for their comfort such as toilets, showers, comfortable seating and overnight accommodation be reviewed. I would also like to see the policies examined and reviewed in the light of evidence of risk factors (if any) rather than being based on traditional exclusionary attitudes.

A review of the policies towards the presence of family and friends would be helpful in implementing woman-centred care. The provision of pay telephones in each labour room would be helpful in the linkmanship role and would also reduce the isolation of woman from their family and from their children in particular. Following the birth it should be up to the mother and father to decide if they want to have visitors in the labour room. If they do wish this and the woman feels up to it then time should be set aside. This is particularly important in regard to the rituals surrounding the admission of the baby into the family, and for the woman to have the direct support of her own mother or father.

Future research

Having developed a theory to explain the happenings in the labour ward the next logical step is that of further testing the categories. Further research in this area will have important implications both for the support of woman in labour and for the father in the labour room.

A detailed inquiry is needed into the power differentials between parents and the health professionals and in particular the midwives. An

exploration of how the ideological underpinnings are manifest in practice and can be distinguished from the rhetoric that shows as adherence to other practices. It would be useful to further look at information seeking and knowledge needs of fathers in the labour room. More work is required on the development of a supportive model for fathers e.g. how to be a support and advocate and it would add to the body of knowledge if further research was done on the actual process of becoming a father with emphasis on the birth rituals.

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Appendices.

Appendix One. Ethics Letters



The Royal Liverpool
University Hospitals
BROADGREEN AND LIVERPOOL

Appendix One. Ethics Letters

Prescot Street, Liverpool L7 8XP

Tel: 0151 706 2000 Fax: 0151 706 5806

Direct Line:

Fax:

Your ref:

Our ref: GMB/ARM/96/71

Please ask for: Ext. 3158

Please quote our reference

27th June 1996

Mrs. I. Walton,
Principal Lecturer Midwifery,
Head of Midwifery Education,
School of Healthcare,
Liverpool John Moores University,
79 Tithebarn Street,
Liverpool,
L2 2ER.

Dear Mrs. Walton,

THE ROLE OF THE FATHER IN THE LABOUR WARD

Thank you for your letter of 21st June 1996 together with copy of patient information and questionnaire. The Ethics Committee formally approves the abovementioned protocol.

Yours sincerely,

G. M. Bell,
Chairman, Ethics Committee

LO.DB

17 October 1996

Mrs I Walton
School of Health
Tithebarn Street

Dear Mrs Walton

I am pleased to inform you that the Ethics Committee has now considered your application for approval of the project entitled:

An anthropological study of birth with particular emphasis on the presence of the father

and I am happy to confirm that it was approved, subject to the following proviso:

1. the questionnaires must be validated and copies sent to the Chair (Dr D Billington) for action.

The Ethics Committee approval is given on the understanding that:

- (i) any adverse reactions/events which take place during the course of the project will be reported to the Committee immediately;
- (ii) any unforeseen ethical issues arising during the course of the project will be reported to the Committee immediately;
- (iii) any change in the protocol will be reported to the Committee immediately.

Please note that ethical approval is given for a period of five years from the date granted and therefore the expiry date for this project will be October 2001. An application for extension of approval must be submitted if the project continues after this date.

I am enclosing form EC5 and would be grateful if you could spare the time to complete the questionnaire and return it to me.

Yours sincerely



Lisa Olsen
Secretary, Ethics Committee
0151 231 3365

Encs.

Copy to Supervisor - Prof C Cunningham

Appendix Two. Consent Form

CONSENT FORM- Couples in the labour ward

THE ROLE OF THE FATHER IN LABOUR

We are willing to be participants in the above research.

We have discussed it with Irene Walton and have been given the information sheet and a verbal explanation of the research. We understand that all information we give will be treated in absolute confidence and that we will never be identified personally.

We also know we have the right to withdraw at any time.

Signed

| | |
|-------|-------|
| | |
| | |



THE ROLE OF THE FATHER IN LABOUR

PHASE ONE INFORMATION SHEET

I am a midwife researcher from the Liverpool John Moores University conducting a study that looks at the role of the father in the labour ward. Very little research has been done to find out how the father can help his partner whilst she is in labour and what the expectations and needs of the couple are.

This study will look at what fathers, mothers and health professionals think is the role of the father in the Labour ward. It will also look at the interactions in the labour ward and it will attempt to find out what the needs of fathers whose partners are giving birth actually are. The support needed by women from both the professionals and the fathers will also be considered.

A part of phase one I would like you to complete a short questionnaire which will take about five minutes to complete.

If you do not wish to participate in this study your wishes will be respected. whatever you decide will not affect the care of your partner or yourself in any way.

All the information you give will be treated in the strictest confidence. You will never be identified personally and your details will not be passed on to anyone else.

YOU HAVE THE RIGHT TO WITHDRAW AT ANY TIME FROM THIS RESEARCH

Thankyou very much

Irene Walton
Principal Lecturer Midwifery

Tel: 0151 231 4219

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THE ROLE OF THE FATHER IN LABOUR

PHASE ONE INFORMATION SHEET

I am a midwife researcher from the Liverpool John Moores University conducting a study which looks at the role of the father in the labour ward. Very little research has been done to find out how the father can help his partner whilst she is in labour and what the expectations and needs of the couple are.

This study will look at what fathers, mothers and health professionals think is the role of the father in the Labour ward. It will also look at the interactions in the labour ward and it will attempt to find out what the needs of fathers whose partners are giving birth actually are. The support needed by women from both the professionals and the fathers will also be considered.

A part of phase one I would like you to take part in a short interview which will take about thirty minutes.

If you do not wish to participate in this study your wishes will be respected. whatever you decide will not affect the care of your partner or yourself in any way.

All the information you give will be treated in the strictest confidence. You will never be identified personally and your details will not be passed on to anyone else.

YOU HAVE THE RIGHT TO WITHDRAW AT ANY TIME FROM THIS RESEARCH

Thankyou very much

Irene Walton
Principal Lecturer Midwifery
School of Health
79 tithebarn Street
Liverpool L2 2ER

Tel: 0151 231 4219



Liverpool John Moores University

THE ROLE OF THE FATHER IN LABOUR

A midwife researcher from Liverpool John Moores University is conducting a study into the role of the father in the delivery room.

You may be approached when first admitted to the delivery suite to take part in the study.

Your co-operation will be greatly appreciated.

However you are under no obligation and if you choose not to take part your wishes will be respected.

Confidentiality will be maintained at all times.

You have the right to withdraw from the study at any time



THE ROLE OF THE FATHER IN LABOUR

PHASE TWO INFORMATION SHEET

I am a midwife researcher from the Liverpool John Moores University conducting a study which looks at the role of the father in the labour ward. Very little research has been done to find out how the father can help his partner whilst she is in labour and what the expectations and needs of the couple are.

This study will look at what fathers, mothers and health professionals think is the role of the father in the Labour Ward. It will also look at the interactions in the labour ward and will attempt to find out what the needs of fathers whose partners are giving birth actually are. The support needed by women from both the professionals and the fathers will also be considered.

As part of Phase Two I would like you to allow me to act as an observer in the labour ward. I am a practising midwife and a midwife teacher but will not take an active part in the delivery of care. I will accompany the midwife and your privacy at other times will be respected.

If you do not wish to participate in this study your wishes will be respected. Whatever you decide will not affect the care of your partner or yourself in any way.

All the information you give will be treated in the strictest confidence. You will never be identified personally and your details will not be passed on to anyone else.

YOU HAVE THE RIGHT TO WITHDRAW AT ANY TIME FROM THIS RESEARCH

Thankyou very much

Irene Walton
School of Health
79 Tithebarn Street.
Liverpool L2 2ER

Tel: 0151 231 4219

THE MEDICAL UNDERGRADUATE CURRICULUM

HIPPOCRATIC OATH

One of the first acts of the World Medical Association, when formed in 1947 on the initiative of the British Medical Association in an attempt to unite the profession throughout the world in a single community, was to produce a modern restatement of the *Hippocratic Oath*, known as the *Declaration of Geneva*, and to base upon it an International Code of Medical Ethics.

The Faculty of Medicine is now responsible for the education of a wide range of health care professionals: nurses dentists, diagnostic and therapy radiographers, occupational therapists, orthoptists and physiotherapists as well as doctors.

In our Faculty the Declaration of Geneva has been slightly modified so that it is appropriate for all health care professions. During the Faculty's graduation ceremony, the new graduates in all these professions each affirm the amended version (World Medical Association 1994 and Liverpool 1995) of the Declaration:

At the time of being admitted as a Member of my Profession,
I solemnly pledge myself to consecrate my life to the service of humanity;

I will give to my teachers the respect and gratitude which is their due;
I will practise my profession with conscience and dignity;

The health of those in my care will be my first consideration;
I will respect the secrets that are confided in me, even after a patient has died;

I will maintain by all the means in my power the honour and the noble traditions of my profession,
My colleagues will be my sisters and brothers;

I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation or social standing to intervene between my duty and my patient;

I will maintain the utmost respect for human life from its beginnings, even under threat,
and I will not use my specialist knowledge contrary to the laws of humanity.

I make these promises solemnly, freely and upon my honour.

Dr P H Dangerfield

THE UNIVERSITY
of LIVERPOOL
Faculty of Medicine

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Aims & Objectives
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Specialist Modules
Phases of Learning
Approach to Learning

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Assessment
Administration
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Student support & welfare
Student Health
Who's who
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Medicine
University home page

Appendix Five First semi structured questionnaire

Semi Structured Interview - New fathers

1. Did you want to be with your partner whilst she was in labour?
2. Why was this?
3. What did you expect of yourself whilst she was in labour?
4. How do you think you affected your partner whilst she was in labour?
5. Do you think the staff was affected by your presence, and if so how?
6. Do you think your presence affected the course of the labour and if so how?
7. How do you think your presence affected the care your partner received?
8. How do you think your presence affected the amount of control your partner had over her labour?
9. How do you think the presence of men in general in the labour ward affected your partner?
10. What do you think the role of the father in the labour ward is?
11. What guidance, education or specific resources do you think the father needs to fulfil his role?

Appendix Six Quantitative questionnaires

**LIVERPOOL JOHN MOORES UNIVERSITY
SCHOOL OF HEALTH**

FATHERS IN THE LABOUR WARD

**QUESTIONNAIRE FOR EXPECTANT
FATHERS**

I am a researcher/midwifery lecturer from John Moores University examining the role of the father in the labour ward.

To date very little research has been done to find out how he can help his partner whilst she is in labour. I am investigating this and also looking at the needs and expectations of the couple:

I will be very grateful if you would spend a few minutes completing this questionnaire for me. Please return the completed questionnaire in the enclosed stamped addressed envelope.

**All the information will be treated in the strictest
confidence**

Thankyou

**Irene Walton
Principal Lecturer, Midwifery**

May 1998

SECTION ONE. The presence of the father

Please circle your response.

In your opinion:

1. In the **absence** of specific obstetric problems should the father attend the **labour**?
 - (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never
2. In the **presence** of serious obstetric problems e.g. haemorrhage (bleeding) should the father attend the **labour**?
 - (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never
3. In the **absence** of specific obstetric problems should the father attend the **birth**?
 - (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never
4. In the **presence** of specific obstetric problems e.g. haemorrhage (bleeding), or procedures e.g. forceps should the father attend the **birth**?
 - (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never
5. Do you think that most men want to be with their partners in **labour**?
 - (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely

6. Do you think that most men want to be with their partners at the birth?
- (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
7. Do you think men are generally under pressure from their partners to attend the labour and birth?
- (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
8. Do you think men are generally under pressure from the maternity staff to attend the labour and birth?
- (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never
9. Do you think men are generally under pressure from other men to attend the labour and the birth?
- (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never
10. Do you think that generally the presence of fathers affects the way care is delivered by the midwife for the better?
- (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never

11. Do you think that generally the presence of the father affects the way care is delivered by the **doctor**, for the better?
- (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never

SECTION TWO. The role of the father

12. The following is a list of behaviours identified by parents and professionals as forming the supportive role of the father in labour and at the birth.

Please rate them in your opinion of importance.

| | |
|---------------------|---|
| Not Important | 1 |
| Rarely important | 2 |
| Sometimes Important | 3 |
| Important | 4 |
| Very Important | 5 |

The father should,

| | Please circle | | | | |
|---|----------------------|---|---|---|---|
| (I) Give encouragement to the woman in labour | 1 | 2 | 3 | 4 | 5 |
| (ii) Help the woman through the experience. | 1 | 2 | 3 | 4 | 5 |
| (iii) Help to relieve the pain | 1 | 2 | 3 | 4 | 5 |
| (iv) Reinforce breathing exercises | 1 | 2 | 3 | 4 | 5 |
| (v) Make the woman feel safe | 1 | 2 | 3 | 4 | 5 |
| (vi) Validate her experience | 1 | 2 | 3 | 4 | 5 |
| (vi) Have shared memories | 1 | 2 | 3 | 4 | 5 |
| (vii) Help the midwife | 1 | 2 | 3 | 4 | 5 |
| (viii) Help the doctor | 1 | 2 | 3 | 4 | 5 |
| (ix) Be watchful on behalf of the woman | 1 | 2 | 3 | 4 | 5 |
| (x) Be the focus of the woman's anger | 1 | 2 | 3 | 4 | 5 |
| (xi) Distract the woman | 1 | 2 | 3 | 4 | 5 |
| (xii) Act as an advocate | 1 | 2 | 3 | 4 | 5 |

13. Do you think you will be an effective supporter to your partner in labour?

- (i) Definitely yes
- (ii) Probably yes
- (iii) Depends on circumstances
- (iv) Probably not
- (v) Definitely not

- (i) Extremely frightened
- (ii) Somewhat frightened
- (iii) Slightly apprehensive
- (iv) Not frightened at all

SECTION THREE THE CONTEXT

Please circle the points in question 15 using the following scoring system.

- No provision 1
- Inadequate provision 2
- Quite good provision 3
- Good provision 4
- Excellent provision 5
- Don't know 6

15 Does the labour ward in which your partner will deliver make provision for the physical comfort of the fathers in the following respects.

- | | | | | | | |
|----------------------------------|---|---|---|---|---|---|
| (i) Comfortable seating | 1 | 2 | 3 | 4 | 5 | 6 |
| (ii) Overnight accommodation | 1 | 2 | 3 | 4 | 5 | 6 |
| (iii) Toilets | 1 | 2 | 3 | 4 | 5 | 6 |
| (iv) Showers | 1 | 2 | 3 | 4 | 5 | 6 |
| (v) Tea/Coffee making facilities | 1 | 2 | 3 | 4 | 5 | 6 |

SECTION FOUR Education for Labour and Birth (Antenatal classes)

In your experience is your partner's antenatal class;

16. Held at a suitable time for you to attend?

- (i) Always
- (ii) Frequently
- (iii) Occasionally
- (iv) Rarely
- (v) Never
- (vi) Don't know

17. Held at a place to which you will go?

- (i) Always
- (ii) Frequently
- (iii) Occasionally
- (iv) Rarely

- (v) Never

If your partner attends antenatal classes please answer questions 18, 19 and 20. If not please go to question 21

18(a) Do you attend the antenatal classes with your partner?

- (i) Always
- (ii) Frequently
- (iii) Occasionally
- (iv) Rarely
- (v) Never

19. Do you consider the content of the antenatal classes to be an adequate preparation for you to learn how to support your partner in labour and at the birth?

- (i) Excellent preparation
- (ii) Generally good
- (iii) Adequate
- (iv) Mostly inadequate
- (v) Very inadequate

20. To what extent do you consider that your attendance at antenatal classes will improve the situation for your partner in labour?

- (i) No effect
- (ii) Slight improvement
- (iii) Much improvement
- (iv) Great improvement
- (v) Do not know

SECTION FIVE

Gender issues

21. Would it have an effect upon you to learn that the midwife/doctor is a parent her/himself?

- (i) Negative effect.
- (ii) Slightly negative effect.
- (iii) No effect
- (iv) Slight positive effect
- (v) Very positive effect

22. Do you consider the gender (male or female) of the midwife/doctor relevant to the care your partner will receive ?.

- (i) Relevant
- (ii) Irrelevant

23 **If you think it is relevant**

Is it important for the midwife to be a

- (i.) Man
- (ii) Woman

24 If you think it is relevant

Is it important for the doctor to be a

- (i) Man
- (ii) Woman

25. Do you think the presence during labour and birth of your partner's mother or female companion would be more helpful to her than your presence?

- (i) Much more helpful
- (ii) Slightly more helpful
- (iii) No difference
- (iv) Slightly less helpful
- (v) Much less helpful

26. Do you think that the presence of men in general in the labour ward will be in any way **embarrassing** to your partner?

- (i) Frequently
- (ii) Occasionally
- (iii) Rarely
- (iii) Never

27. Do you think that the presence of men in general in the labour ward will be in any way **threatening** to your partner?

- (i) Frequently
- (ii) Occasionally
- (iii) Rarely
- (iii) Never

SECTION SIX Personal information

Please circle the relevant information.

28. (i) Under 20 years old
 (ii) 21 - 30 years old
 (iii) 31 -35 years old
 (iv) 36- 40 years old
 (iv) Over 40 years old
29. Are you to be a father for the
 (1st) (2nd) (3rd) (4th) (5th) (more than 5th) time

Thankyou for taking the time to complete this questionnaire.

If you have any other comments please use the space below.

Please return to
Irene Walton
School of Health
John Moores University
79 Tithebarn Street,
Liverpool L2 2ER
Tel No. 0151 231 4219

LIVERPOOL JOHN MOORES UNIVERSITY

SCHOOL OF HEALTH

FATHERS IN THE LABOUR WARD

**QUESTIONNAIRE FOR
PROFESSIONALS**

I am a researcher/midwifery lecturer from John Moores University examining the role of the father in the labour ward.

To date very little research has been done to find out how he can help his partner whilst she is in labour. I am investigating this and also looking at the needs and expectations of the couple:

I will be very grateful if you would spend a few minutes completing this questionnaire for me. Please return the completed questionnaire in the enclosed stamped addressed envelope.

**All the information will be treated in the strictest
confidence**

Thankyou

**Irene Walton
Principal Lecturer, Midwifery**

May 1998

SECTION ONE. The presence of the father

Please circle your response.

In your opinion:

1. In the **absence** of specific obstetric problems should the father attend the **labour**?
 - (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never
2. In the **presence** of serious obstetric problems e.g. haemorrhage (bleeding) should the father attend the **labour**?
 - (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never
3. In the **absence** of specific obstetric problems should the father attend the **birth**?
 - (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never
4. In the **presence** of specific obstetric problems e.g. haemorrhage (bleeding), or procedures e.g. forceps should the father attend the **birth**?
 - (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never
5. Do you think that most men want to be with their partners in **labour**?
 - (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely

6. Do you think that most men want to be with their partners at the birth?
- (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
7. Do you think men are generally under pressure from their partners to attend the labour and birth?
- (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
8. Do you think men are generally under pressure from the maternity staff to attend the labour and birth?
- (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never
9. Do you think men are generally under pressure from other men to attend the labour and the birth?
- (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never
10. Do you think the presence of fathers affects the way care is delivered by the midwife for the better?
- (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never

11. Do you think that generally the presence of the father affects the way care is delivered by **doctors**, for the better?
- (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never

SECTION TWO. The role of the father

12. The following is a list of behaviours identified by parents and professionals as forming the supportive role of the father in labour and at the birth.

Please rate them in your opinion of importance.

| | |
|---------------------|---|
| Not Important | 1 |
| Rarely important | 2 |
| Sometimes Important | 3 |
| Important | 4 |
| Very Important | 5 |

The father should,

| | Please circle | | | | |
|---|----------------------|---|---|---|---|
| (I) Give encouragement to the woman in labour | 1 | 2 | 3 | 4 | 5 |
| (ii) Help the woman through the experience. | 1 | 2 | 3 | 4 | 5 |
| (iii) Help to relieve the pain | 1 | 2 | 3 | 4 | 5 |
| (iv) Reinforce breathing exercises | 1 | 2 | 3 | 4 | 5 |
| (v) Make the woman feel safe | 1 | 2 | 3 | 4 | 5 |
| (vi) Validate her experience | 1 | 2 | 3 | 4 | 5 |
| (vi) Have shared memories | 1 | 2 | 3 | 4 | 5 |
| (vii) Help the midwife | 1 | 2 | 3 | 4 | 5 |
| (viii) Help the doctor | 1 | 2 | 3 | 4 | 5 |
| (ix) Be watchful on behalf of the woman | 1 | 2 | 3 | 4 | 5 |
| (x) Be the focus of the woman's anger | 1 | 2 | 3 | 4 | 5 |
| (xi) Distract the woman | 1 | 2 | 3 | 4 | 5 |
| (xii) Act as an advocate | 1 | 2 | 3 | 4 | 5 |

13. In your experience is the father usually an effective supporter to the woman in labour?
- (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never

On the following question feel free to circle as many answers as you wish.

A In your experience which of the following characteristics would you associate with lack of helpfulness by the fathers to labouring women.

- (I) Lack of maturity
- (ii) Lack of experience
- (iii) Unpleasant character
- (iv) Unstable relationship
- (v) Lack of knowledge about labour and birth processes
- (vi) Low educational status
- (vii) Low social class

B. Have you ever personally found that the fathers are **verbally** abusive to the mothers?

- (i) Frequently
- (ii) Occasionally
- (iii) Rarely
- (iv) Never

C Have you personally found that the fathers are **physically** abusive to the mothers?

- (i) Frequently
- (ii) Occasionally
- (iii) Rarely
- (iv) Never

D. Have you personally found that the fathers are **verbally** abusive to the **midwives**?

- (i) Frequently
- (ii) Occasionally
- (iii) Rarely
- (iv) Never

E. Have you personally found that the fathers are **physically** abusive to the **midwives**?

- (i) Frequently
- (ii) Occasionally
- (iii) Rarely
- (iv) Never

F Have you personally found that the fathers are **verbally** abusive to the **doctors**?

- (i) Frequently
- (ii) Occasionally
- (iii) Rarely
- (iv) Never

G Have you personally found that the fathers are **physically** abusive to the **doctors**?

- (i) Frequently

- (ii) Occasionally
- (iii) Rarely
- (iv) Never

14 Do fathers ever demonstrate fear in the labour ward?

- (i) Always
- (ii) Frequently
- (iii) Occasionally
- (iv) Rarely
- (v) Never

SECTION THREE THE CONTEXT

Please circle the points in question 15 using the following scoring system.

| | |
|----------------------|---|
| No provision | 1 |
| Inadequate provision | 2 |
| Quite good provision | 3 |
| Good provision | 4 |
| Excellent provision | 5 |
| Do not know | 6 |

15 Does the labour ward in which you work make provision for the physical comfort of the fathers in the following respects.

- | | | | | | | |
|----------------------------------|---|---|---|---|---|---|
| (i) Comfortable seating | 1 | 2 | 3 | 4 | 5 | 6 |
| (ii) Overnight accommodation | 1 | 2 | 3 | 4 | 5 | 6 |
| (iii) Toilets | 1 | 2 | 3 | 4 | 5 | 6 |
| (iv) Showers | 1 | 2 | 3 | 4 | 5 | 6 |
| (v) Tea/Coffee making facilities | 1 | 2 | 3 | 4 | 5 | 6 |

SECTION FOUR

Education for Labour and Birth (Antenatal classes)

16. Are antenatal classes held at suitable time for fathers to attend?

- (i) Always
- (ii) Frequently
- (iii) Occasionally
- (iv) Rarely
- (v) Never

17 Does the siting of antenatal classes encourage the attendance of men?

- (i) Always
- (ii) Frequently
- (iii) Occasionally
- (iv) Rarely
- (v) Never

18(b) In the labour ward do the fathers generally seem well informed about the processes of labour and birth?

- (i) Always
- (ii) Frequently
- (iii) Occasionally
- (iv) Rarely
- (v) Never

19. Do you consider the content of the antenatal classes to be an adequate preparation for fathers to learn how to support their partners in labour and at the birth?

- (i) Excellent preparation
- (ii) Generally good
- (iii) Adequate
- (iv) Mostly inadequate
- (v) Very inadequate

20 To what extent do you consider that the father's attendance at antenatal classes improves the situation for women in labour?

- (i) No improvement
- (ii) Slight improvement
- (iii) Much improvement
- (iv) Great improvement
- (v) Do not know

SECTION FIVE

Gender issues

21. Where the midwife/doctor is a parent her/himself does this affect the credibility of her/his practice to the women and their partners?

- (i) Negatively
- (ii) Slightly negatively
- (iii) No effect
- (iv) Slightly positively
- (v) Very positively

22. Do you consider the gender of a woman's attendants to be relevant to the care she receives?

- (i) Relevant

- (ii) Irrelevant
- 23. **If you think it is relevant**
Is it important for the **midwife** to be a
 - (i.) Man
 - (ii) Woman
- 24. **If you think it is relevant**
Is it important for the **doctor** to be a
 - (i) Man
 - (ii) Woman
- 25. Do you think the presence during labour and birth of the woman's mother or female companion is more helpful to her than the presence of the father?
 - (i) Much more helpful
 - (ii) Slightly more helpful
 - (iii) No difference
 - (iv) Slightly less helpful
 - (v) Much less helpful
- 26. Do you think that the presence of men in general in the labour ward is in any way **embarrassing** to the women?
 - (i) Always
 - (ii) Frequently
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never
- 27. Do you think that the presence of men in general in the labour ward is in any way **threatening** to the women?
 - (ii) Frequently
 - (i) Always
 - (iii) Occasionally
 - (iv) Rarely
 - (v) Never

SECTION SIX Personal information

Please circle the relevant information.

- 28 (i) Under 25 years old
 (ii) 26 - 30 years old
 (iii) 31 -35 years old
 (iv) 36- 40 years old
 (iv) Over 40 years old

29. Are you
 (i) Male
 (ii) Female
 (iii) Midwife
 (iv) Doctor
 (v) A parent

Thankyou for taking the time to complete this questionnaire.

If you have any other comments please use the space below.

Please return to
Irene Walton
School of Health
John Moores University
79 Tithebarn Street,
Liverpool L2 2ER
Tel No. 0151 231 4219

Appendix Seven. Letter to Parents after the Birth

Dear

I am the researcher who you allowed to be present when was born in January. I hope all is well with you and I expect is growing big and bouncy now.

If you remember I asked if I could visit you for a short interview with about his role in the labour ward. I wonder if you are still willing to talk to me for a short while in the next few weeks. I will ring at the end of the week to make an appointment if that is all right with you.

Thanks

Irene Walton

Date

**PAGE
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IN
ORIGINAL**

Appendix Eight. Second semi structured questionnaire (to couples after the birth)

1. Was this the first time you have ever been present at the birth of a baby?
2. Why did you decide to be present this time?
3. What are your overall impressions of being at the birth?
4. Did you have any expectations and if so, were they met?

ACTIVE

5. Did you feel in control in the labour room and were you able to stand up and move about?
6. Were you free to come and go as you pleased?

PHYSICAL & VERBAL SUPPORT

7. How were you supportive to.....when she was in labour?

KNOWLEDGE

8. Did you feel you had enough knowledge and information to be useful?

EXCLUDED & TEAM MEMBER

9. How would you describe your relationship with the midwives?
10. How would you describe your relationship with the doctors?

OBSERVER

11. Did you feel like an observer or watchful for?

EMOTIONS & BABY JOY

12. How did you feel when was in labour and at the birth?
13. Did you find anything embarrassing or frightening and if so how did you deal with it?

DISTANCING

14. Did you ever feel like leaving?

PHYSICAL CONTACT/ INTIMACY

15. Were you able to have as much privacy as you needed?
16. Were you able to have as much physical contact as you would have liked?

FAMILY

17. Did anyone support you during this time and if so how?
18. How would you sum up the role of the father in the labour room?
19. What do men need to fulfil this role?
20. How has the experience affected your relationship if at all?

Appendix Nine. Quantitative Data

The Questions

There were 29 questions common to all and 8 extra questions (A-G) to the health professionals relating specifically to the demonstration of aggression and fear by the father in the labour ward. Question 18 was different for parents (18a) and health professionals (18b) and was analysed separately. The questionnaire was divided into six sections (appendix six). These were as follows

| <u>Section</u> | <u>Title</u> | <u>Number of Questions</u> |
|----------------|--------------------------------|--|
| 1. | The presence of the father | 10 . |
| 2. | The role of the father | 3 (12 sub parts to Q.12) 8 questions A-G for health professionals |
| 3. | The context | 1 with 5 subparts |
| 4. | Education for labour and birth | 5 |
| 5. | Gender issues | 7 |
| 6. | Personal Issues | 2 |

A five point Likert scale was generally used except for Questions,

B -G (4 point). It was considered that the item *always* was not suitable.

15 (6 point), Expectant fathers and mothers might not know what facilities were available and so an extra item *don't know* was added.

22, 23, 24 A (2 point). The respondents were asked to choose between one or the other item e.g. is the gender of the midwife relevant or not relevant.

Analysis of Data

Means were calculated and a one way ANOVA was conducted on the results. Where significant differences were found between groups a Tukey HSD was used to determine which groups were significantly different from one another.

Results

Significance was found between the answers to questions regarding the following:

Table 13.3 Multiple one way analysis of variance of questionnaire items showing significance

| SECTION | Exp. Fth N=3 9 MEA N | Exp. mth N=3 8 MEA N | New fth N=58 MEA N | New Mth N=57 MEA N | Mid wife N=34 MEA N | Docto r. N=6 MEA N | ANOVA RESULT |
|---|-------------------------------------|-------------------------------------|--------------------------------|--------------------------------|---------------------------------|--------------------------------|---------------------------|
| ONE The father's presence 1. Do you think that most men want to be with their partners in labour? | 1.77 sd,.58 | 1.92 sd,.59 | 1.71 sd,.68 | 1.61 sd,.59 | 1.94 sd.42 | 2.17 sd.41 | F=3.018(4,227) p<0.019 |
| TWO The role of the father 12(iii) The father should | 3.77 sd1.04 | 3.45 sd,1.27 | 4.05 sd,1.18 | 3.65 sd,1.20 | 3.15 sd,1.02 | 4.00 sd,1.26 | F=3.148(4,227),p<0.015 |

| | | | | | | | |
|---|----------------------|---------------------|---------------------|---------------------|---------------------|---------------------|------------------------------|
| help to relieve pain | | | | | | | |
| 12(vii) The father should help the midwife. | 2.92 sd,1. 20 | 3.05 sd,1. 16 | 3.41 sd,1. 31 | 2.93 sd,1. 45 | 2.50 sd,1. 26 | 3.00 sd,1. 54 | F(4,227), =2.609p<0.036 |
| 12(viii) The father should help the doctor | 2.53 sd,1. 35 | 2.73 sd,1. 27 | 3.09 sd,1. 49 | 2.51 sd,1. 32 | 2.26 sd,1. 31 | 2.17 sd,0. 98 | F(4,227), =2.643, p<0.035 |
| 12(ix) Be watchful on behalf of the woman. | 3.72 sd,1. 26. | 3.89 sd,1. 31 | 3.85 sd,1. 37 | 3.75 sd,1. 34 | 3.12 sd,1. 30 | 2.67 sd,1. 03 | F(4,227), =2.821,p<0.026 |
| 12(x) Be the focus of the woman's anger | 3.51 sd,1. 27 | 3.05 sd,1. 29 | 4.16 sd,5. 50 | 2.61 sd,1. 32 | 2.71 sd,1. 29 | 2.67 sd,1. 37 | F(4,227), =2.454, p<0.047 |
| 12(xi) Distract the woman. | 3.72 sd,1. 10 | 3.42 sd,1. 22 | 3.55 sd,1. 27 | 2.96 sd,1. 53 | 2.91 s,1.2 6 | 2.67 sd,1. 21 | F(4,227),=3.6629, p<0.007 |
| 13. Do you think you were/will | 1.90 sd,0. 88 | 1.37 sd,0. 71 | 1.16 sd,0. 67 | 1.09 sd,0. 47 | 2.09 sd,0. 57 | 2.50 sd,1. 05 | F(4,227),=21.941, p<0.000 |

| | | | | | | | |
|--|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|---------------------------|
| be an effective supporter to your partner in labour? | | | | | | | |
| THREE The Context 15. Provision for the physical comfort of the father in respect to (ii) Overnight | 4.38 sd,2.36 | 4.18 sd,2.26 | 2.78 sd,2.26 | 3.14 s,2.20 | 1.88 sd,1.01 | 2.00 sd,0.89 | F(4,227), =9.675p<0.000 |
| 15. Provision for the physical comfort of the father in respect to (iii) Toilet provision accommod | 4.08 sd,1.16 | 4.42 sd,1.41 | 3.02 sd,1.71 | 3.49 sd,1.47 | 3.00 sd,1.04 | 3.00 sd,0.89 | F(4,227), =8.601, p<0.000 |

| ation | | | | | | | |
|--|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|------------------------------|
| 15. Provision for the physical comfort of the father in respect to (iv) Showers | 3.85 sd,2. 06 | 4.63 sd,1. 88 | 2.74 sd,2. 19 | 3.16 sd,2. 23 | 1.32 sd,0. 94 | 1.17 sd,04 1 | F(4,227),=16.089, p<0.000 |
| 15. Provision for the physical comfort of the father in respect to (v) Tea/coffee making facilities | 3.95 sd,1. 67 | 3.68 sd,1. 99 | 2.98 sd,2. 00 | 3.42 sd,1. 93 | 2.21 sd,1. 32 | 3.00 sd,0. 63 | F(4,227),=5.0130 ,p<0.001 |
| 19. Do you think the content of antenatal classes is an adequate | 1.62 sd,1. 18 | 1.63 sd,1. 28 | 1.07 sd,1. 31 | 0.79 sd,1. 13 | 1.94 sd,1. 50 | 0.83 sd,1. 33 | F(4,226), =5.280,p<0.000 |

| | | | | | | | |
|---|------------------|------------------|------------------|------------------|------------------|------------------|-------------------------------|
| preparation for fathers for labour and birth? Classes | | | | | | | |
| 20. Attendance causing an improvement in care of the woman. | 2.26 sd, 1.27 | 2.16 sd, 1.55 | 1.28 sd, 1.48 | 1.09 sd, 1.49 | 2.06 sd, 1.52 | 1.17 sd, 1.84 | F(4,226), = 6.066, p<0.000 |
| FIVE Gender Issues 25. Do you think the presence of the woman's mother or female companion is/would be more helpful than that of yourself/th | 3.51 sd, 1.19 | 3.61 sd, 1.22 | 3.22 sd, 1.31 | 3.45 sd, 1.28 | 2.47 sd, 1.08 | 2.83 sd, 0.98 | F(4,226), = 5.080, p<0.001 |

| | | | | | | | |
|--|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|------------------------------|
| e father? | | | | | | | |
| 26. Do you think the presence of men in general make the woman embarrassed? | 2.76 sd,1. 24 | 3.21 sd,1. 38 | 4.12 sd,1. 31 | 4.30 sd,1. 36 | 3.65 0.69 | 3.33 sd,1. 37 | F(4,226),=11.705, p<0.000 |
| 27. Do you think the presence of men in general make the woman feel threatened ? | 3.51 sd,1. 32 | 4.61 sd,1. 13 | 4.62 sd,1. 09 | 4.79 sd,0. 84 | 3.94 sd,0. 69 | 4.33 sd,0. 82 | F(4,227), =11.803p,0.000 |

Post hoc test

Tukey test at p<0.05 shows that the difference between the groups in the following questionnaire items is as follows;

Section One. The presence of the father
Likert scale

- (i) Always
- (ii) Frequently
- (iii) Occasionally
- (iv) Rarely
- (v) Never

Q6. Men’s desire to be with their partners in labour.

a) Midwife (x̄ = 1.94, sd=0.42) & new mother (x̄=1.61, sd =0.59)

Section two. The role of the father

Likert scale

- (i) Not important
- (ii) Rarely important
- (iii) Sometimes important
- (iv) Important
- (v) Very important

Q.12 (iii). Whether or not the father should help relieve pain

- . a) Midwife ($x=3.15$, $sd=1.02$) & new father ($x=4.05$, $sd=1.18$)

Q.12 (vii). Whether or not the father should help the midwife.

- a) Midwife ($x=2.50$, $sd=1.26$) & new father ($x=3.4$, $sd=1.31$)

Q.12 (viii). Whether or not the father should help the doctor

- a) Midwife ($x=2.26$, $sd=1.31$) & new father ($x=3.09$, $sd=1.49$)

Q.12 (ix). The fathers' watchfulness on behalf of the mothers

- a) Midwife ($x=3.12$, $sd=1.30$) & expectant mother ($x=3.89$, $sd=1.31$)
- b) Midwife ($x=3.12$, $sd=1.30$) & new father ($x=3.85$, $sd=1.17$)

Q.12 (x). The father as the focus of anger

- a) New mother ($x=2.61$, $sd=1.32$) & new father ($x=4.16$, $sd=5.50$)

Q12. (xi). Should the father distract the woman?

- a) Expectant father ($x=3.72$, $sd=1.10$) and new mother ($x=2.96$, $sd=1.53$)

Q.13. The father as an effective supporter

Likert scale

- (i) Definitely yes
- (ii) Probably yes
- (iii) Depends on circumstances
- (iv) Probably not
- (v) Definitely not

- a) Expectant father ($x=1.90$, $sd=0.88$) and expectant mother ($x=1.37$, $sd=0.71$)
- b) Expectant father ($x=1.90$, $sd=0.88$) and the new father ($x=1.16$, $sd=0.67$)

- c) Expectant father ($x=1.90$, $sd=0.88$) and new mother ($x=1.09$, $sd=0.47$)
- d) Midwife ($x=2.09$, $sd=0.57$) and expectant mother ($x=1.37$, $sd=0.71$)
- e) Midwife ($x=2.09$, $sd=0.57$) and expectant father ($x=1.90$, $sd=0.88$)
- f) Midwife ($x=2.09$, $sd=0.57$) and new mother ($x=1.09$, $sd=0.47$)

Section three The Context

Likert scale

- (i) No provision
- (ii) Inadequate provision
- (iii) Quite good provision
- (iv) Good provision
- (v) Excellent provision
- (vi) Don't know

Q15 (ii). Provision for the physical comfort of the father in respect to,

- a) Overnight accommodation.
- b) Midwife ($x= 1.90$, $sd= 1.01$) & expectant father ($x= 4.38$, $sd=2.34$)
- c) Midwife ($x= 1.90$, $sd= 1.01$) & expectant mother ($x= 4.18$, $sd=2.26$)
- d) Midwife ($x= 1.90$, $sd= 1.01$) & new mother ($x= 3.14$, $sd=2.20$)
- e) Expectant father ($x= 4.38$, $sd=2.33$) & new mother ($x= 3.14$, $sd=2.20$)
- f) Expectant father ($x= 4.38$, $sd=2.33$) & new father ($x= 2.78$, $sd=2.26$)

Q.15 (iii). Toilets

- a) Expectant mother ($x=4.42$, $sd=1.410$ and new father ($x=3.02$, $sd=1.71$).

Q.15 (iv). Showers

- a) Midwife ($x= 1.32$, $sd=0.94$) and expectant father ($x=3.85$, $sd=2.06$)
- b) Midwife ($x= 1.32$, $sd=0.94$) and new father ($x=2.74$, $sd=2.19$)
- c) Expectant father ($x=3.85$, $sd=2.06$) and new father ($x=2.74$, $sd=2.19$)
- d) Expectant mother ($x=4.63$, $sd=1.88$) and new father ($x=2.74$, $sd=2.19$)
- e) Expectant mother ($x=4.63$, $sd=1.88$) and new mother ($x=3.16$, $sd=2.23$)

Q.15 (v). Tea/coffee-making facilities

- a) Midwife ($x= 2.21$, $sd= 1.32$) & expectant father ($x= 3.95$, $sd= 1.67$)
- b) Midwife ($x= 2.21$, $sd= 1.32$) & expectant mother ($x=3.68$, $sd=1.99$)
- c) Midwife ($x= 2.21$, $sd= 1.32$) & new mother ($x= 3.42$, $sd= 1.93$)

Section three. Education for labour and birth

Likert scale

- (i) Excellent preparation
- (ii) Generally good.
- (iii) Adequate.
- (iv) Mostly inadequate
- (v) Very inadequate

Antenatal classes in respect to;

Q19. Adequacy of content

- a) New mother (0.79 , $sd=1.13$) & midwife ($x=1.94$, $sd=1.50$)
- b) New mother (0.79 , $sd=1.13$) & expectant father ($x= 1.62$, $sd=1.18$)

Likert score

- i) No effect
- ii) Slight improvement
- iii) Much improvement

- iv) Great improvement
- v) Do not know

Q.20. Attendance causing an improvement in the woman's care

- a) Expectant father ($x=2.26$, $sd=1.27$) & new father ($x=1.28$, $sd=1.48$)
- b) Expectant father ($x=2.26$, $sd=1.27$) & new mother ($x=1.09$, $sd=1.49$)
- c) Expectant mother ($x=2.16$, $sd=1.55$) & new father ($x=1.28$, $sd=1.48$)
- d) Expectant mother ($x=2.16$, $sd=1.55$) & new mother ($x=1.09$, $sd=1.49$)
- e) Midwife ($x=2.06$, $sd=1.52$) & new mother ($x=1.09$, $sd=1.49$)

Section five. Gender Issues

Likert Scale

- (i) Much more helpful
- (ii) Slightly more helpful
- (iii) No difference
- (iv) Slightly less helpful
- (v) Much less helpful

Q.25. Helpfulness of the woman's mother or female friend in relation to the father's helpfulness

- a) Midwife ($x= 2.47$, $sd= 1.08$) & expectant father ($x= 3.51$, $sd= 1.19$)
- b) Midwife ($x= 2.47$, $sd= 1.08$) & expectant mother ($x=3.61$, $sd= 1.22$)
- c) Midwife ($x= 2.47$, $sd= 1.08$) & new father ($x= 3.22$, $sd= 1.31$)
- d) Midwife ($x= 2.47$, $sd= 1.08$) & new mother ($x= 3.45$, $sd= 1.28$)

Questions 26 and 27

Likert Scale

- (i) Always

- (ii) Sometimes
- (iii) Occasionally
- (iv) Rarely
- (v) Never

Q.26. The presence of men making the woman feel embarrassed

- a) Expectant father ($x= 2.76$, $sd= 1.24$) & new father ($x= 4.12$, $sd= 1.31$)
- b) Expectant father ($x= 2.76$, $sd= 1.24$) & new mother ($x= 4.30$, $sd= 1.36$)
- c) Expectant father ($x= 2.76$, $sd= 1.24$) & midwife ($x= 3.65$, $sd= 0.69$)
- d) Expectant mother ($x=3.21$, $sd= 1.38$) & new father ($x= 4.12$, $sd= 1.31$)
- e) Midwife ($x= 3.65$, $sd= 0.69$) & new mother ($x= 4.30$, $sd= 1.36$)

Q.27. The presence of men making the woman feel threatened

- a) Expectant father ($x=3.51$, $sd=1.32$) & expectant mother ($x=4.61$, $sd=1.13$)
- b) Expectant father ($x=3.51$, $sd=1.32$) & new father ($x=4.62$, $sd=1.09$)
- c) Expectant father ($x=3.51$, $sd=1.32$) & new mother ($x=4.79$, $sd=0.84$)
- d) Midwife ($x=3.94$, $sd=0.69$) & new father ($x=4.62$, $sd=1.09$)
- e) Midwife ($x=3.94$, $sd=0.69$) & new mother ($x=4.79$, $sd=0.84$)

Results showing no significant differences between the groups

There was no significant difference between and within groups in answer to questions regarding:

Section One. The presence of the father.

- Q.1. Whether or not the father should be present at the *labour* in the *absence* of specific obstetric problems (Mean 1.250, sd 0.572)
Always
- Q.2. Whether or not the father should be present at the *labour* in the *presence* of specific obstetric problems (Mean 1.849, sd 1.120)
Always
- Q.3. Whether or not the father should be present at the *birth* in the *absence* of specific obstetric problems (Mean 1.310, sd 0.643)
Always
- Q.4. Whether or not the father should be present at the *birth* in the *presence* of specific obstetric problems. (Mean 1.767, sd 1.039)
Always
- Q.6. Whether or not men want to be at the birth. (Mean 1.806, sd 0.604)
Always
- Q.7. Men being under pressure from their partners. (Mean 2.328, sd 0.845) *Frequently*
- Q.8. Men being under pressure from the staff. (Mean 3.616, sd 1.149)
Occasionally
- Q.9. Men being under pressure from the other men. (Mean 3.371, sd 1.097) *Occasionally*
- Q.10. The effect on the presence of the father on the care given by the midwife. (Mean 3.664, sd 1.322) *Occasionally*
- Q.11. The effect of the presence of the father on the care given by the doctor. (Mean 3.935, sd 3.575) *Occasionally*

Section Two. The role of the father

- Q12. The behaviour of the father in regard to,
- i) Giving encouragement to the woman. (Mean 3.935, sd 3.575)
Sometimes important

- ii) Helping her through the experience. (Mean 4.608, sd 0.846) *Important*
- iii) Helping to reinforce breathing exercises. (Mean 3.802, sd 1.200) *Sometimes important*
- iv) Making her feel safe. (Mean 4.453, sd 0.948) *Important*
- v) Validating her experience. (Mean 4.056, sd 3.624) *Important*
- vi) Having shared memories. (Mean 4.569, sd 3.512) *Important*
- vii) Acting as an advocate. (Mean 3.599, sd 1.275) *Sometimes important*

Section Three. The context

Q.12. Provision for the physical comfort of the father in respect to,
 a) Comfortable seating. (Mean 3.724, sd 1.232) *No provision.*

Q.A Characteristics of fathers associated with unhelpfulness.

- i) Lack of maturity (Mean 0.875, sd 0.335)
- ii) Lack of experience (Mean 0.425, sd 0.501)
- iii) Unpleasant character (Mean 0.744, sd 0.442)
- iv) Unstable relationship (Mean 1.025, sd 1.672)
- v) Lack of Knowledge about labour & birth (Mean 0.700, sd 0.464)
- vi) Low educational status (Mean 0.205, sd 0.409)
- vii) Low social class (Mean 0.128, sd 0.339)

Q.B Experience of verbal abuse to mothers (Mean 3.000, sd 0.784)
Rarely

Q.D. Experience of verbal abuse to midwives. (Mean 2.375, sd 0.628)
Occasionally

Q.F. Experience of verbal abuse to doctors. (Mean 2.625, sd 0.628)
Occasionally

Q.C. Experience of physical abuse to mothers. (Mean 3.675, sd 0.572)
Never

- Q.E Experience of physical abuse to midwives.(Mean 3.625, sd 0.667)
Never
- Q.G. Experience of physical abuse to doctors. (Mean 3.795, sd 0.409)
Never
- Q.14 Health professionals' questionnaire). Demonstration of fear by the fathers in the labour ward (Mean 2.675, sd 0.656) *Slightly apprehensive*
- Q14 Fathers own feelings of fear. (Mean 3.117, sd 0.929) *Slightly apprehensive*

Section Four. Education for labour and birth (Antenatal classes

Antenatal Classes,

- Q.16. Suitability of timing. (Mean 1.874, sd 1.557) *Always*
- Q.17. Suitability of siting. (Mean 1.550, sd 2.003) *Always*
- Q. 18(a) Frequency of attendance at classes of men in the study
(Mean 2.560, sd 1.123) *Frequently*
- Q.18 (b) Fathers being apparently well informed in the labour ward.
(Mean 2.275, sd 1.154) *Frequently*

Section Four. Gender Issues

- Q.21. The fact that a midwife or doctor was a parent themselves. (Mean 3.509, sd 1.097) *No effect*
- Q.22. The gender of the midwife or doctor. (Mean 1.651, sd 0.487)
relevant
- Q.23.Should the midwife be a man or woman? (Mean 0.698, sd 0.955)
Not answered
- Q.24. Should the doctor be a man or a woman (Mean 0.353, sd 0.747)
Not answered.