

New Mothers' Experiences of Agency During Prenatal and Delivery Care: Clinical Practice, Communication and Embodiment

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Full Text: Headnote ABSTRACT: Health research suggests that personal agency plays a key role in health experiences. In this qualitative analysis of the experiences of 40 recent mothers accessing healthcare services from physicians and midwives, we found that agency is linked to democratic relationships that support women's access to and discussion of relevant health information. While most participants wanted to participate more actively in their care, problematic physician-patient communication hampered their ability to exercise personal agency. This was not true for midwives who have a model of practice that emphasizes education and choice. Different understandings of embodiment affect the development of health care relationships. KEY WORDS: Pregnancy, midwives, personal agency, social determinants of health, physician-patient communication, qualitative health research, health care relationships. INTRODUCTION Health care is portrayed in the media (especially in nations with universal coverage) to be under siege and many different stakeholder groups including the public often cite this perception in an effort to support their often diverging interests. However, in spite of the recent escalating costs the current system has generally not improved significantly and often fails to produce acceptable outcomes, especially in relation to chronic health conditions. Future complications include the increased health care needs of an aging population and the anticipated retirement of a significant proportion of those currently active in the health care professions (Statistics Canada, 1995; Tarlov, 2000; Townson, 1999). Many agree that health care reform is needed to cope with the increasing pressures but there is considerable conflict from different stakeholder groups about the direction that health care reform should take. For example, governments typically exert pressures to control costs (Evans, 1984; Townson, 1999), while physicians seek to maintain their control as gatekeepers to the system. Alternative health practitioners, who argue that they have the potential to contribute to more holistic strategies that advance a health promotion want to participate in providing insured health services (Gordon, 1996; Koenig, 1999). Finally, patient groups, who have increasing access to health information, owing in part to the revolution in technological communicative media, are demanding a more active role in their own health care (Clarke & Evans, 1998; Maeside, 1991; Morrow, 1997). In general, health consumers are demanding access to health education and medical information, a choice in treatments, and greater respect for their decisions (Dimatteo, 1994; Morrow, 1997; Mullett & Coughlan, 1998; Street, 1992, 2001). Dissatisfied with depersonalized consultations, patients want to be able to voice their opinions, research their own health issues, and access services from a variety of health professionals. Patients increasingly recognize that experienced symptoms do not stand in a one-to-one relationship with measurable pathology, and they want physicians who will listen to and respect their accounts of their physical complaints and concerns (Mullett & Coughlan, 1998). We believe that the interest of patients in becoming more actively involved in their care can be understood as the desire to exercise greater personal agency in relation to their health and their health care relationships. In our study, we use a qualitative approach (based on a combination of grounded theory and interpretive phenomenology) to examine the health care experiences of maternity patients from their point of view, and to explore how medical relations and the utilization of different communicative strategies in consultations either promote or interfere with perceptions of agency. As a research method phenomenology allows the researcher to understand phenomena from participants' own perspectives; describing "the total structure of lived experience, including the meanings that these experiences have for the individuals who participate in them" (Omery, 1983, p. 50; see also Kvale, 1996; Taylor & Bogdan, 1984). Lived

experience refers to the way in which individuals encounter everyday situations in relation to their interests, aspirations, personal concerns and background understandings (Benner, 1985). Because it engages critically with the individual's conscious social reality from their perspective and without a priori theories about their causal explanation and as free as possible from unexamined presuppositions and assumptions (Schutz, 1962; Spiegelberg, 1975), we believe that a qualitative approach is of particular value in developing a more adequate and comprehensive understanding of the complex phenomenon of human agency in the health care relationship. We interviewed 40 new mothers who had accessed health care services from a variety of practitioners, including male and female fee-for-service physicians, salaried physicians and midwives, recently included in provincially insured services. This article, as just one aspect of the larger study, reports on the experiences of women receiving care from fee-for-service physicians and midwives. The purpose of this article is twofold. First, we explore how agency might be understood in the context of health care, from the point of view of the patient, and we examine aspects of the health care relationship that either promote or undermine perceptions of personal agency for new mothers. Personal agency, as we discuss below, is always contextualized by broader societal relations and social institutions, including those communicative strategies that characterize health care consultations. Finally, we briefly consider how different philosophical understandings of embodiment might influence the development of health care relationships that support the active involvement of patients in their own care. For example, we found that although a majority of women wanted more medical and health information, and wanted to participate more actively in their care, differentials in power between physicians and patients continue to hamper the development of more democratic relationships that allows a more effective communicative scenario and better knowledge sharing. This was true for physicians, regardless of gender. It was not true for midwives who have a model of practice that encourages the formation of democratic relationships and emphasizes health education and respect for the choices and embodied experiences of women. More democratic health care relationships not only facilitate feelings of greater competence, autonomy, and choice for women during pregnancy and childbirth, they also provide a template for future action that encourages women to become more informed and more willing to exercise agency in caring for themselves, for their infants, and for their families. In other words if supported by their clinical relationships during the important transition to motherhood many new mothers experiences of personal agency are generalized to many health behaviours and relationships as well to other aspects of their lives.

Agency, Communication and the Healthcare Relationship As noted above, patients are demanding a more active role in their care. Increased patient involvement and more democratic health care relationships not only re-humanize care, they bear directly on such medical issues as good health outcomes and success of medical treatment. While health researchers have focussed attention on physician-patient interactions, many investigations have been concerned with finding ways to increase the power of physicians to gain compliance from patients to medical advice (Beisecker, 1990; Ainsworth-Vaughn, 1994; Fisher & Groce, 1990; Tarlov, 1992; Waitzkin, 1995). In addition, even though there has been a general discussion in the academic literature of the value of attending to psychological, social and communicative needs of patients in medical interventions (Barry, Stevenson, Britten, Barber & Bradley, 2001; Phillips, 1996; Roter, Hall, Marisca & Nordstrum, 1998), a majority of social-scientific investigations into relations between physicians and patients has consistently shown that physicians are more likely to use a wide range of structural and discursive props to consolidate their power and often these strategies tend to limit the participation of the patient in the way they would like (Glowers, 2002; Coulter, 2002; Mullett & Coughlan, 1998; Roter et al 1998; Waitzkin, 1985). In studies of physician-patient communication, it has been shown that diagnostic interactions tend to be characterized by hierarchically and sequentially arranged phases of physician-initiated questions and patient responses (Fisher & Groce, 1985; Liederman & Grisso, 1985; Mishler, 1985). There is an asymmetrical power differential in such interactions and physicians tend to use discursive strategies to tightly control consultations and to reinforce their authority as clinical professionals (Marvel, Epstein, Flowers & Beckman 1999; Frankel & Beckman, 1989). For example,

physicians may actively inhibit patient participation by ignoring or interrupting the patient, or by asking additional questions that reestablish the authoritative medical agenda (Marvel, Epstein, Flowers & Beckman, 1999; Ten-Have, 1987; Weijts, Widdershoven, Kok, & Tomlow, 1993). They may also restrict the flow of information to patient, often withholding critical elements of the diagnosis and treatment (Pinder, 1990) yet may actually believe that they have communicated more effectively (Phillips, 1996). For women, the medical consultation can be even more problematic (Davis, 1988). Compared to male patients, women's accounts of their symptoms are twice as likely to be ignored (Fisher & Groce, 1990) and their questions are much more likely to be interrupted (Marvel et al 1999). While these discursive strategies reward the physician by diffusing uncertainty and by foreclosing challenges to diagnosis and treatment recommendations, it is now recognized that health outcomes are affected by the attendance of physicians to the needs, expectations, definitions of problems and requests for information as communicated by patients (Barry, Stevenson, Britten, Barber & Bradley, 2001; Brody, 1987; Cassell, 1985; Charon, 1986; 1989; Helman, 1990; Weijts, 1994). Poor patient-physician communication has been cited one of the major causes for malpractice complaints (Stewart, Brown, Weston & McWhinney 1999). Indeed, patients who feel they have a stake in planning and decision-making processes tend to be more committed to treatment regimens and they tend to experience greater satisfaction and improved health outcomes (Barry, Stevenson, Britten, Barber & Bradley, 2001; Greenfield, Kaplan & Ware, 1985; Kreps, O'Hare & Glowers, 1994; Mintz, 1992; Stewart & Roter, 1989; Winefield & Murrell, 1991). The importance of effective physician-patient communication may be widely recognized, but more recent investigations show that patients continue to express dissatisfaction with their health care relationships, especially in relation to communication with their clinicians (Brunt, Chappell, McClure & Cassells, 1998; Clarke and Mischler, 1992; Mullett & Coughlan, 1998; Stephenson & Holmes, 2000). While it is evident that power differentials and problematic communication stand to hamper the ability of patients to participate more meaningfully in their own care, there is little information on the structure, content or meaning of personal agency from the point of view of the patient. The research findings presented in this paper contribute an understanding of those practices and communicative strategies, from the patient's point of view, that facilitate or undermine the experience and exercise of agency in the health care relationship.

METHODS In general, there has been a paucity of health research conducted from the point of view and experiences of patients; most research in the health sector tends to take up the interests of clinicians (Street, 2001; Morrow, 1997). Thus, the orienting assumptions as well as the tendency to utilize questionnaire research designs tends to ignore, or at best limit, the subject of patient agency. In this investigation, we use a qualitative approach, combining grounded theory and interpretive phenomenological methods to illuminate the meaning and content of the experience of agency for new mothers in the context of their health care experiences during pregnancy and childbirth. Phenomenology rejects the "illicit reification of scientific contents" and the inadequate understandings of human activity to which it gives rise in favor of a focus on the "ultimacy of the temporal process and the constitutive function of social praxis" (Rosenthal & Bourgeois, 1991, p. 3). Both grounded theory and phenomenology provides a way of discovering how phenomena present themselves in the lived experience of human existence in a way that is grounded both temporally and historically. And because the focus is the faithful description of the subjective aspect of lived experience, the meaning of that experience must be drawn from the perceptions of the participants themselves. As a research method, a qualitative approach allows the researcher to more fully explore participants' embodied experiences, opinions, perceptions, emotional responses and feelings without seeking causal explanations and without imposing a preexisting conceptual order on them (Spiegelberg, 1975). Even though the researcher attempts to "bracket" or suspend predisposing conceptualizations of the phenomenon under study, this does not imply that the interpretation or analysis of the interviews is presuppositionless. Rather, presuppositions and modes of influence are made explicit (Kvale, 1996). The concept of agency, as we understand and use it, is not a private or internal experience but a social phenomenon where individual experiences and perceptions are deeply intertwined with cultural meaning systems, societal institutions and communicative processes. As such, the

experience of agency is always constituted inter-subjectively. In this study, we wanted to explore the meaning of agency for pregnant women, accessing care from a variety of different care providers. Previous research has found that in general female physicians have longer diagnostic interviews than their male counterparts, and take a longer time discussing the patient's history. Female physicians also tend to be more positive in their comments, seemed more interested in forming relationships with their patients, were more responsive to requests for information and asked more questions (Roter & Hall 1998; Roter, Lipkin & Korsgaard, 1991; Weijts, 1994). For this reason, we wanted to explore differences in the experiences of maternity patients with both female and male physicians. In addition, since January of 1997, prenatal, birthing and postnatal care provided by midwives has been included in the insured services covered by the British Columbia provincial Medical Services Plan. Thus, in addition to comparing the experiences of patients of male and female physicians, a further comparison was made to investigate the experiences and opinions of expecting mothers who chose midwifery services under the new plan. Research Participants Researching the experiences and opinions of new mothers offered some unique opportunities. While most younger people are ill-equipped to formulate informed opinions concerning relations with medical institutions, new and/or expecting mothers have a much more intimate knowledge of medical institutions and medical interactions. Pregnancy and maternity represent occurrences that have only recently been medicalized. In the strictest sense pregnancy is not an "illness" and in the overwhelming majority of births, mother and child leave care in full health (McNiven, Hodnett & O'Brien-Pallas, 1992; Scully, 1980). Also, pregnancy and childbirth have been the subject of both media and public attention, with a focus on the options and choices available to women during their birthing experiences. Challenges to the medicalization of childbirth, from both midwives and feminist critiques of medical institutions and practices that subordinate and control women, have played a large part in shaping the context of care and in expanding the range of pregnancy and birthing alternatives available. Thus, we understood that the experiences and opinions of pregnant and birthing women had the potential to more clearly reveal the effects of formal medical structures and relationships on their perceptions of their choices and treatment. Once the research protocol received ethical approval from the University of Victoria ethics committee (working under the TriCouncil guidelines for research in Canada) participants in this qualitative study were contacted through various means. Signs inviting participation were posted in public places frequented by new mothers, i.e., at various pre-natal classes, post-natal classes and mothers' drop-in centres throughout the Greater Victoria health region. The intent was to interview as broad a spectrum of new mothers as possible. The participants (consisting of 40 new mothers ranging in age from 19 to 45) were of divergent socioeconomic status and included both married and single mothers. Mothers were recruited in each of the following categories: those who consulted male physicians who were paid via fee-for-service; those who consulted female physicians paid via fee-for-service; those who consulted physicians of either gender paid by salary; and those who consulted licensed midwives. As mentioned previously, this article discusses the experiences of participants with fee-for-service physicians and midwives only. Patients, all of whom were volunteers, contacted the researchers and at this time were provided full details of the research project in order to facilitate their written informed consent to participation. Research Protocol Once recruited, research participants were invited to choose a time and place for the interview that would accommodate their unique infant care schedules. The shortest interview lasted 45 minutes and the longest, approximately 2 hours. All interviews were audio-taped, coded to ensure anonymity, and transcribed. All participants provided basic background information about their present living circumstances, level of education, age and income. To more adequately understand the participants' perceptions of agency in their health care interactions, and in keeping with both a grounded theory and phenomenological approach, a semi-structured qualitative interview protocol was utilized. In general, the interview protocol was designed to encourage the discussion of issues as deemed important by the participants, and allowed them considerable control over the range and depth of topics to be discussed. Most participants freely discussed key areas of interest with little, if any, prompting. The main discussion was broached with broad, open-ended questions

related to their experiences with the health care system. They included their pattern of health service use; opinions of the health system in general; experiences with their physicians and/or midwives; general experiences of support; experiences during the prenatal, birthing and postnatal periods; experiences of choice in interactions with their practitioners; and level of satisfaction with clinicians and health institutions. Although broad critical areas of concern were identified beforehand by the protocol, the bulk of the analytical process (including the identification of major themes and patterns) was dependent on and directly generated by the participants' concerns and experiences as freely discussed and recorded. In qualitative approaches to inquiry, analysis is not an isolated stage, but permeates the entire research process, including the interview stage where the researcher begins the process of condensing and interpreting the meaning of the narratives and experiences offered by the research participant (Kvale, 1996). The data for this inquiry include the transcribed interviews and the researchers' observational and reflexive notes obtained after each interview. While there is no single phenomenological method per se, we were guided by Giorgi's method for phenomenological analysis (1975; 1994; see also Spiegelberg, 1975). Five steps were involved in this analysis. First, the transcribed interviews were read through to get an overall impression or sense of the whole. Second, "natural meaning units" or significant statements, as expressed by the participants, were identified. Third, for each significant statement, a theme was formulated. This involved spelling out the meaning of the statement as simply as possible. The fourth step involved organizing the clusters of themes and interrogating these more succinct formulations in terms of the specific purpose of the study, i.e., "What constitutes agency in the context of the health care relationship?" and "How do care-providers encourage (or discourage) their patients to participate more fully and meaningfully in their own health care?" Finally, in the fifth step, the essential, non-redundant themes of the entire interview were tied together in an exhaustive description. This process was repeated for all 40 interviews. New information or different meanings were incorporated into the descriptive statement, and exemplars or examples of participants' narrated experiences were preserved. Particular attention was paid to those themes or patterns that recurred, both within individual transcripts and across all interviews. In addition to condensing the expressed meanings of the interviews, we also categorized participants' experiences in relation to the type of health care provider consulted. As in most qualitative research, the question of rigor cannot be determined by recourse to quantitative criteria of validity, reliability and generalizability. Instead, our goal is to produce an interpretation that is empirically grounded and that represents accurately the meaningfulness of participants' lived experience. The measures we have taken to enhance the plausibility and trustworthiness of the findings include collecting data through a systematic, academically supervised process; reflexively documenting the research process; and striving for an objectivity that expresses fidelity to the phenomena investigated (Kvale, 1996).

RESULTS Understanding "Agency" in Healthcare Interactions Because concepts such as agency and self-efficacy are not words used in everyday practical life, we explored a variety of terms that would capture the concept of being able to make and act on choices, and to feel a sense of personal control. In the initial pilot interviews we discovered that independence elicited a more general discussion from participants of the experience of acting in their own interests. We introduced the question concerning independence at an early stage in the interview process so that information could be obtained regarding how participants understood this concept in general. As the interview progressed, we asked participants to revisit the concept of independence in relation to their actual health care interactions. We learned that the understanding of the abstracted concept of independence, decontextualized and removed from everyday practical interests, was impoverished when compared to the understanding that emerged from discussion of the practical activity of obtaining health care services. When asked how they understood independence at the outset of the interview process, the overwhelming majority of participants reported that independence represented the ability to make choices in their lives, and that it was always tied to economic issues. In other words, limited monetary resources were seen as an impediment to independence; greater financial security was seen to increase the ability to make choices. This is a reasonable expectation in an industrial consumer-oriented society where the ability to

choose is generally connected to the ability to purchase commodities. A smaller number of participants (primarily those with postsecondary education) linked knowledge and education with greater independence and the ability to make informed choices. This finding is consistent with those of other studies which have found that patients with higher levels of education are more active in seeking health related information (i.e., Pendleton &Bochner, 1980; Waitzkin, 1985). However, when contextualized by the practical experience of their health care interactions, almost all of the participants discussed how their medical and birthing needs were met by having as much information as possible. In other words, while only some well-educated participants were able to discuss how access to information is linked to their sense of control in an abstract form, in a discussion of practical matters, a majority of participants viewed health education and medical information as central to the ability to make informed choices, and to feel in control of their health during pregnancy and childbirth. In summary, agency/independence in health care interactions is understood by participants as the ability to access and discuss medical and health-related information, to make informed choices, and to have their decisions respected by their health care providers. Concrete examples of the experience of agency/independence further revealed that the ability to identify alternatives and make choices was always interpenetrated with socially mediated relations and communication. For example, most participants reported a greater sense of personal control where clinicians allowed free discussion and worked co-operatively to identify alternatives and solutions. Participants also expressed a preference for mediated and personal sources of information. Rather than individually research medical and health information and act alone, most wanted a relationship with a clinician who would support their needs for education and information via communicative means.

Health Care Relationships with Physicians

The most surprising result in the analysis was that there was no noticeable effect of clinician gender on reports of satisfaction or dissatisfaction from participants. New mothers generally reported problematic treatment from both male and female physicians but the few satisfactory reports included both male and female clinicians. Instead, satisfaction was linked to specific behaviors and attitudes. The majority of participants with problem relationships reported that dissatisfaction was due to the feeling that the physician did not care, and lacked respect for them. Lack of care and respect were typically demonstrated through problematic communication. Excerpts from participants' interviews below provide examples of problematic patient-physician relationships, from the patient's point of view: I went to the hospital because I was in pain but they just gave me Tylenol and sent me home-It turned out later that I had a gall bladder problem-they weren't listening to me I asked him what the effects of the birth control pill were and he just said "a lot less than the effects of becoming pregnant". He wouldn't answer my questions. He was really gruff ... I always had to ask and his answers were always too short. I never felt entirely comfortable asking questions They treat me like-because I'm part Native-I must be a drunk or something-or a drug addict. This doctor tried to lecture me about taking care of myself better and not drinking while I'm pregnant I'm in there basically ten minutes-sometimes three-she doesn't facilitate exploring anything Finally, patients expressed dissatisfaction with physicians who were unconvinced or skeptical when patients described symptoms that could not be verified through the use of standard diagnostic procedures. In some cases, physicians blamed patients' psychological faculties for chronic illnesses that eluded diagnostic testing, or that failed to respond to standard treatments: They make you feel like you're doing something wrong-I'm nervous about everything I say-like I'm. some kind of hypochondriac This one doctor wouldn't help-he said I was a hypochondriac but we made him do the tests and that's when we found out I had cancer On the other hand, there were some participants who reported caring and supportive relationships with both female and male physicians. Satisfaction with clinical relationships was always related to a democratic style of interaction. The behaviors and attitudes most linked to satisfaction are, in order of importance: physicians who listen to patients' concerns; physicians who make patients feel comfortable and treat them respectfully; being included in decisions regarding treatment and given choices if possible; and physicians who are knowledgeable and if unfamiliar with particular issues will research patients' questions. Participants also appreciated the time in appointments to allow a full discussion of their concerns. Some patients commented that

waiting was not a problem if physicians were respectful and allowed sufficient time for consultation. He was great-he was patient and quiet and really took the time to talk to you, you waited a long time He was very relaxed and laid back-not like the other one. I could ask him a lot of questions which was much better than the other one who just told me what to do I've always known that I can say "no, I don't want to do this". We discuss it first. She gives me pros and cons and she wouldn't tell me what to do-it was up to us I like it that my doctor will be a resource for information for me-if he doesn't know he will research it for me and even phones me when he has something-he's really good As mentioned previously, most participants reported that the ability to choose is always linked to access to relevant information. Even for participants who reported satisfactory relationships with physicians, there were only four (out of 30) who reported that their needs for information and the ability to make choices were supported by their physician. Participants who received care from physicians reported that the best sources of information were books, friends, family and the internet, in descending order of importance. Not one single patient of a physician rated their doctor as "the best" source of information on health matters even though many participants expressed a desire that they should be.

Health Care Relationships with Midwives This group of new mothers expressed the greatest satisfaction with prenatal, birthing and post-natal services. The difference between the level of satisfaction with midwives as compared to the much lower level of satisfaction with physicians and obstetricians was overwhelming. In contrast to the experiences of participants receiving care from physicians, midwives were overwhelmingly reported as both the "main" and "best" source of prenatal, birthing, and parenting information by those accessing care in this manner. Seven out of the 10 mothers who consulted midwives reported that their need for health education and medical information was fully met in the context of the clinical relationship. Further, a majority of midwifery clients freely discussed how their interactions with their clinician made them feel better equipped and more confident in their abilities to negotiate the psychological and physical aspects of pregnancy and childbirth. In addition, they reported that the relationship gave them resources for making informed choices in relation to healthcare services, in general:

She (the midwife) gave me every bit of information I needed along with all the books she lent me A great reference library too-that was cool I had all the information I needed to make choices. I didn't feel like I was a patient or that I had a medical problem Suddenly I was opened up to this whole world-from going from believing that? doctors know everything-to questioning everything. I learned from the midwives all this stuff I didn't know before All this information and education-it made me feel really empowered It was nice to talk to someone who was really supportive of our choices-and she was really into education and I could support that Access to relevant information and the ability to make choices were also consequential for those giving birth in a hospital setting. Midwifery clients were more knowledgeable about both the birthing process and standard hospital procedures, and they were better prepared to be more assertive and make their needs known. For example, midwifery clients were more likely to remain mobile during labour; were able to resist routine administration of medications; and were more assertive about their choices regarding the care and feeding of a new infant. Unless specifically prompted by the patient, hospital staff did not inform new mothers of choices they could make in relation to immediate after-birth interventions. Generally, patients of physicians did not know that they had any say over certain aspects of care for their new infant, such as the application of silver nitrate and injection with vitamin K. Clients of midwives were all aware of the choices they could make and had plans that were communicated to the staff by the midwife or another support person. It was nice having the information the midwife gave us-to make it more of a plan because when you're there (the hospital) it's hard to make decisions I say she (the midwife) pretty largely increased my independence-she informed me on all sorts of things-tests that I would decide on taking or not I felt really empowered and excited-I found I could ask questions and make choices. I loved it-it was more like talking about what your worries are. If it wasn't for them (the midwives) I would have done what I was told. I felt I could say no to things I didn't want I felt that I was very self-confident about what I wanted and what I was doing during the labour-and felt that (the midwife) supported me in this. I was able to make choices for the most part It was totally up to us whether we had the tests done. They (the

midwives) gave us the information and from that we figured out what we wanted. In summary, participants' experiences with their midwives inspired a sense of confidence in their ability to make choices and decisions, and facilitated their ability to exert control over the birthing process at the hospital. Many patients that had experienced good communication with their clinician and had experienced the relationship as contributing to their personal agency also reported that such positive experiences were factors in encouraging them to have more confidence in getting their needs met in general. This was especially important with regards to finding other positive clinical relationships that would meet their needs for feeling respected, a more democratic style of communication and a more holistic approach to knowledge. Unfortunately new mothers were very pessimistic about changing problematic clinical behavior and reported that the best way to augment their sense of personal agency was to find a more respectful clinician. The overwhelming majority of new mothers who experienced clinical relationships that fostered their own sense of personal agency were those who were clients of midwives. Before I would go to the doctor without knowing an awful lot ... it turns out now that I have everything that's out there I will not stay with a doctor I don't like again I left her (her physician) because she does not believe in a lot of things-including physiotherapy Suddenly I was opened up to this whole world-from going from believing that doctors know everything-to questioning everything Since being with___ (the midwife) through the pregnancy I've looked into more alternative ways of dealing with my health concerns quite a lot more

DISCUSSION

In examining participants' experiences with physicians and midwives, those reporting more caring and respectful interactions with their care-providers also expressed greater satisfaction with their health care relationships. Caring and respectful relationships alone, however, did not always create the conditions for participants to experience and exercise personal agency. For participants to feel meaningfully involved in their care, they required clinicians to support their need to access medical and health information, to discuss alternatives, and to assist them in making informed choices. Democratic health care relationships that foster the ability to exercise personal agency do not only result in greater satisfaction, we believe that they provide a template for future action that encourages individuals to become more informed and competent in caring for themselves and their families. While our investigation confirms that most maternity patients want more health education and a greater role in their own care, we found that physicians tend to practice and communicate in ways that limit patient involvement in their care, and that foreclose opportunities for patients to exercise personal agency. Communicative strategies that reinforce the power of the physician, and limit the participation of patients, originate in dualistic medical structures and relations that separate and valorize the physical aspects of medical intervention from psychological and social factors, even though these can be demonstrated to play a key role in experiences of health and recovery from illness. For the most part, scientific medicine has been successful in representing itself as ideologically and philosophically neutral. Yet the dominant paradigm of scientific medicine developed from both the metaphysics and scientific work of René Descartes, who conceptualized the body as a functioning machine. From this perspective, the body is understood in terms of its constituent elements and interactions, disease is conceptualized as a defect in the biological or chemical processes of the body, and the thrust of modern medical therapeutics has involved treating the body as a mechanical object; manipulating components, substituting parts, altering inputs and outputs, and regulating processes (Leder, 1992). At the site of interaction between patient and health institutions, scientific medicine assumes a model of the patient that divorces their biological systems from their psychological and socio-cultural contexts. The "real" objects of investigation for the physician are those biological organs and biochemical processes that have been rendered separate from the subject of experience. In addition, increasing medical specialization has fuelled the division of the body into ever smaller biological units, each of which is investigated in isolation from their environmental and social contexts (Tarlov, 2000). This combination of dualism and reductionism, arising in the Cartesian model of embodiment, both underpins and structures the practice of medicine. And even though this model has enjoyed overwhelming success in improving standards of living and the ability to fight infectious disease (Harrington, 1999), it introduces distortions and limitations into medical practice today (Leder, 1992). Not only

can it be depersonalizing and dehumanizing, it limits the ability of patients to participate in their care, and it undermines the ability of medicine to adequately address increasing rates of disability and suffering due to chronic diseases, often related to stress, lifestyle, emotions, environmental agents, and lack of personal control (Brundtland, 2000; Feeney, Guyatt & Tugwell, 1986). Physicians may recognize the value of attending to psychological and social variables in medical interactions, but the philosophical basis for medical practice makes it difficult to integrate the biological, psychological and social dimensions of health and illness. In contrast to patients of physicians, clients of midwives enthusiastically reported their positive experiences with pregnancy, labor and childbirth. Their high levels of satisfaction with their care were intimately connected to their perceptions of having better access to information and the ability to make choices that were "right" for them. For midwives, communication is at the heart of the health care relationship, providing the means to develop trust and become more familiar with the particulars of a client's life. Regular consultations, usually aimed at assessing the progress of the pregnancy, also allows the midwife to create the conditions for a necessary learning process surrounding prenatal health and birthing. Working as mentors, midwives assist clients to interpret medical information and work cooperatively with them to identify alternatives and solutions. This mutuality in a democratic relation is similar to what Vygotsky describes as a "zone of proximal development" (ZPD) where learners and teachers can interact to the positive development of both (Vygotsky, 1978) The Vygotskian perspective attempts to posit an alternative to the reductionistic and dualistic psychological paradigm that underpins most mainstream North American psychological approaches by demonstrating that the self (and by extension, personal agency) is most usefully understood to be interpenetrated by continual learning in communicative and cultural contexts. To be truly human one is always engaged in seeking a ZPD through communicative means. This perspective is one that is shared by both Vygotsky and George Herbert Mead and both believe that the natural environment for humans is one that is permeated by communication and contextualized by societal institutions. Mead's arguments agree with Vygotsky's social-psychological genesis of self and personal agency and in conclusion, ventures that "mind" is primarily a social phenomenon taking shape in the social, communicative sphere and only secondarily a phenomenon of the individual (Mead, 1977). Both Vygotsky and Mead offer arguments that overcome the individual/social divide as well as the mind/body divide that is so problematic for modern clinical practice. Clearly, midwives recognize the importance of the communicative situation in the clinical consultation, but they also base their practice on an understanding of the body that views the physiological and existential dimensions of the body as equally significant and mutually implicative (Leder, 1992). Unlike physicians, midwives are not systematically hampered by a Cartesian model of embodiment that reduces patients to a collection of organ-systems and bio-chemical processes. Instead, midwives base their practice on a model of the body that allows them to address the embodied experiences of clients, along with their fears, concerns, and aspirations. The model of practice used by midwives is consistent with a phenomenological understanding of the "lived body" which directs attention to the way in which the body is always bound up with and directed towards an experienced world. A phenomenological model of the "lived body" necessarily advances a medical practice that takes into account the subjective experiences, social circumstances, and the need of individuals for some control over their wellbeing. Further, it recognizes multiple points of possible intervention with a more holistic therapeutics that draws on the biological, psychological and social resources of an integrated and embodied individual. To improve the quality and effectiveness of health care, our findings demonstrate the value of taking the clinician-patient relationship more seriously at a fundamental philosophical level: to create the conditions for patients to exercise agency and thus participate more actively in avoiding disease and maintaining health. This study examines how personal agency is an important personal need of individuals but that personal experiences are always mediated by socio-cultural means. Relationships with clinical professionals are important to expecting and birthing mothers and clinical interactions that are predicated on a more authoritarian model of interaction and a dualistic understanding of medical practice that ignores actual lived experience are perceived as generally less satisfactory. New mothers

who experience an augmented sense of personal agency in this important and life-changing aspect tend to believe they are capable of rising to other challenges, acting in their own interests and have higher expectations for other clinical relationships. Models of health promotion rely upon ordinary persons to become informed to stay healthy but many clinical relationships tend to work against developing the skills to achieve these goals. Pregnancy and childbirth are not like other health concerns because very few births would normally require major clinical intervention. Unfortunately the modern medicalization of birthing has meant that clinical care has tended to over-pathologize this natural process. One shortcoming of this research with regard to the importance of agency in healthcare is that new mothers don't readily consider themselves as "ill" thus we need to further investigate a number of different clinical problems that are properly designated as necessitating clinical intervention. In this regard, an investigation of the experiences of patients that are diagnosed with minor, chronic and serious illnesses needs to be undertaken with a view to investigating the affect of agency-augmenting clinical relationships on self-care, compliance and satisfaction. In addition we did not differentiate in this research between midwives with a holistic model stemming from the "lay" midwife model of care (such as those that patients in this article accessed) and those midwives who are trained in the mainstream medical model as nurses and who subsequently decided to become midwives. Another direction that we propose to undertake will be an investigation of the experiences of midwifery practitioners from these differing orientations and the affects of their ideology on their models of practice along with how the acceptance of midwifery into the mainstream may have changed delivery and birthing practices in hospitals or how midwifery may have become more congruent to mainstream clinical organization.

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