THE CHOICE OF MATERNITY SERVICE BY PREGNANT WOMEN: AN EXPLORATORY ANALYSIS

by

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Abstract

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Women in their first and second pregnancies, including patients of midwives and obstetricians, planning to deliver in hospitals, a birthing center and homes, were interviewed about their choices of maternity services.

Having made an active choice of a maternity service was important to all. Limitations on freedom of choice were traced to the insurance industry, regarding the malpractice insurance crisis as the cause for a decrease in the number and variety of available maternity services, and to reimbursement policies with limited coverage or which favor hospitals. Individual circumstances, such as physical conditions or financial situation were identified as enhancing or limiting freedom of choice. While aware of their limited control over structural factors affecting their care, women did believe they could gain control on an individual level. The act of service choice was one way to affect care, as was collecting information to affect treatment decisions of attendants.

Three issues underlied women's choices: physical safety, emotional comfort, and control. They were related to one another in perspectives on pregnancy, childbirth and available services, and in the choice process. Physical safety was most important to everybody, holding a medical meaning for respondents opting for hospital care but not for their counterparts opting for out-of-hospital birth. Comfort was seen by obstetricians' patients as inevitably lost in hospitals, but as attainable by midwives' patients opting for in-hospital birth and by those opting for out-of-hospital settings. Total control over care was

realized as unattainable by all; instead, respondents focussed on control over activities during labor.

Their previous experiences made respondents in second pregnancies more informed about pregnancy and childbirth, and about their needs and expectations from a service than those in their first. Yet respondents in the two pregnancy groups did not differ in the nature of their choice process, and in the reasons they used in selecting services.

Findings indicate the importance of contextual factors to the study of real-life decision making. These factors strongly influenced both the process and the final service choice.

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Introduction

Shortly after moving to New York I became pregnant and had to select a service for prenatal care and childbirth. I lacked experience with, and knowledge of the American Health Care system, especially its maternity care services and policies. I also did not know women who had been pregnant and could provide guidance and referrals. These shortcomings forced me to develop my own ways of choosing and evaluating the services. During the first half of my pregnancy I learned about the system by actually using it, i.e. becoming a patient in several different services (a male physician affiliated with a teaching hospital, a hospital clinic, and a joint practice of female physicians and midwives). It was an educational experience in clarifying my needs to myself. It also taught me about my ability, as a consumer and user, to seek information and make choices. Finally, it made me aware of the difficulties women face when they have a real need to be met by the health care system and of the ways these needs are responded to.

My own experience left me with questions about the nature of the choice process in general. I wanted to know whether women saw features of the health-care system, such as professional structures in Medicine and Midwifery, and insurance coverage policies, as potentially limiting their ability to make choices suitable to themselves. I was also interested in women's coping techniques when perceiving themselves as having limitations. The role of other factors as potentially facilitating or inhibiting the decision-making was unclear. Among these factors were past experience of childbirth and making choices in the system, and the perception of available services.

Cross-cultural and historical perspectives reveal that there are, and always have been, many ways to handle pregnancy and childbirth. The recent increase in the number and variety of maternity services in the New York metropolitan area attests to an interest among planners and advocates as well as among users, in the need for such services. Each

such service offers a different childbirth experience, as the combination of human, physical and ecological factors creates a different environment and results in a potentially unique situation. A variety of services would enable women to choose the type of birth they want in the setting of their choice and under the type of care they prefer. For a number of years, various childbirth services have been in existence in the New York metropolitan area, among them hospital settings (teaching and community hospitals, traditional labor and delivery suites, and birthing room environments), an independent birthing center, and homebirth services. Yet the opinions of women on these services and their ability to choose from them has not been sought. It is the main aim of this dissertation to uncover the perspectives of maternity services' users about these services, as they reflect on their processes of choice.

Environmental Psychology offers a particularly useful perspective for the study of women's choices of maternity services. An interdisciplinary area, Environmental Psychology focusses on the interfaces between people and their surroundings, stipulating that for proper understanding of such interfaces, their examination should include factors on various levels in them yet a perspective on the situation as a whole should be kept at all times. This entails not only the identification of factors (individual, interpersonal, physical, socio-political) operating in a situation, but also the way they shape it through their interrelations. Thus, it is the ability to balance the role of individual components against that of the whole that is unique to analyses done in this tradition. Yet it is necessary for an examination of the choice of maternity care services to go beyond the interface of the individual woman with the combination of the human and physical components that constitute a health service, and evaluate the nature of the situation that she prefers, which constitutes the essence of her choice. The nature of the situation is created by its own human and physical components, and is also shaped by the way women perceive it when

they make their choices and afterward, in their reflections on it. It was the aim of this study to try and see such connection between the choices done and women's desires.

The process of actually conducting the study was revealing in regards to the nature of choice. First, my beliefs about women's choices have changed considerably. I started the study believing that there were people who made choices and others who followed someone else's steps or plainly avoided the choice process altogether. I found that among the women I interviewed, everyone was making choices. There were several whose choices reflected an active stance in regards to having the place for birth that they preferred, and others who consciously opted for a passive way of handling the choice process, but no one ignored the choice. I also found that the choice was connected to a larger variety of issues in women's lives, and in more complicated ways than I had expected previously. For instance, parenthood issues such as responsibility toward older children and the ways it affected thinking about the second pregnancy and childbirth were influential in women's choices. Beliefs about the ability of humans in general to control the ways events of nature occur were mentioned by several women when discussing their process of making choice. In general, not only was the choice connected to other parts of women's lives during pregnancy and regarding health care, but it was also related to philosophical and social convictions they held. To understand the choice of maternity services for these women I had to consider in each individual case the context for the choice in her life and its relationship to other issues.

The stage of conducting research differs from its planning stages in that aspects of situations and conditions around which the study had been planned tend to surface in unexpected ways. This study was no exception. One such unpredicted difference between plan and reality was the way in which hospital users distinguished the place and attendant in their perceptions of services. Moreover, they attached a high value to the attendant while

down playing that of the place. Those who opted for out-of-hospital birth attached high values to both the place and the attendant. This unexpected distinction women made between attendant and place had implications on the perceptions and activities related to the choice making. Since hospitals are the most commonly opted-for settings for childbirth in America, their significance yet their near-ignorance by their choosers is a phenomenon by itself, beyond the study of their choice. In the course of doing the study, this phenomenon taught me that the existence of services or their components was not sufficient for determination of their weight in women's perceptions and choices. To understand women's choices adequately, I had to change my own conceptions of the nature of services and their choices.

My personal perspective on the topics covered in the research cannot be ignored. The methods of data collection and analysis clarified my own opinions about issues to myself. Both during the interview and data analysis, I had to confront opinions that were not similar to my own, about an issue that was important to me. It was this very process of repeat juxtaposition of contrasting opinions that made me aware of the subtleties of my own perspective, and increased my caution against influencing the findings in their evaluation and presentation.

The study did answer my initial questions, but the answers and their implications were not necessarily comforting. While the choice process is clearer to me now, I am less settled about women's situation regarding the health care services that we need and use, our ability to choose from them and our relationships with attendants, midwives and physicians included. It seems like at the same time that medicine makes progress, we keep losing ground about our own health care needs and desires. I hope this study will benefit others, as it did me, by raising awareness of to the subtle processes involved around a seemingly benign health care need as pregnancy and childbirth.

The Options, Context and Processes Involved in the Choice of a Maternity Service

The mental and practical activities involved in the choice of a service for prenatal care and childbirth are interwoven. Women have to clarify to themselves what they are interested in for themselves in a service and seek information about services in their geographical areas. Among the available services, they have to see whether their requirements from a service are met. At this stage they may be introduced to factors that affect their freedom of choice. Upon beginning to use a service, they still have to decide whether they want to remain there or try another that might be more satisfactory. Throughout this process, a woman undertakes mental as well as practical tasks. Her activities take place in a socio-political context, in which the insurance industry and the professional structures of the health care professions all play roles. Not every woman encounters all of these contextual structures, but several might, for example, as a result of inability to pay for services that are desirable to them but are not covered by their medical insurance.

Various other factors and forces are part of and influence the nature and course of the choice process. Experience is one such factor, specifically whether the choice is made in the first or second pregnancy. The impact of a previous birth experience needs to be evaluated, whether or not it plays a facilitating role in weighing alternative services, and how it affects perspectives on childbirth in general and expectations for the next one. There is also the effect of an individual's past experience with the health care system, as a user or worker in services.

Relevant scientific and popular writings provided only scanty and partial background about the process of choice of service for childbirth, and lacked perspectives of the women themselves. The major goal of this research was to learn from pregnant women about their choice experiences.

Contextual Structures Involved in the Choice

Social forces and establishments that constitute macro structures with social, political and professional power are part of people's activities. Their influence is so pervasive, that often it is not recognized by individuals, especially in the absence of overt conflict of interests between individuals and such larger structures. It is when such contradictions occur that individuals realize the extent of penetration and impact such establishments have on their daily lives, and this awareness also sharpens their sense of making choices. The insurance industry, professional systems within the health care field, and the structure of maternity services are all part of the context for women's choices.

The insurance industry plays an increasingly important role in shaping the structure and nature of services for childbirth, and in the choices of individuals. The range of childbirth services available to women has shrunk in recent years as a result of the rapid increase of liability insurance premiums which, in turn, has driven a large number of practitioners, among them obstetricians and nurse-midwives, out of practice (Young, 1986). Definitions held by the insurance industry of physical conditions and the "proper" ways of handling them have also affected practice and thus have shaped professional management procedures of such conditions, in the form of "positive" or "negative defensive medicine" (Tancredi & Barondess, 1978). "Positive defensive medicine" implies that practitioners, attempting to protect themselves in case of a lawsuit, employ excessive and potentially harmful procedures in their care. "Negative defensive medicine" means the

avoidance of procedures whenever possible, and usually results in less harm to patients. Influenced by medical professional guidelines for "proper care", the insurance industry has set its own rules, which individual practitioners of obstetrics and midwifery are forced to follow, or they risk losing their insurance policies and thus the license to practice. Since the medical philosophy has tended to see pregnancy and childbirth as sickness conditions (Devitt, 1977; Nash & Nash, 1979), bound by their insurance policies they tend to practice positive defense medicine, and women are limited to only such services to select from.

The type of insurance coverage an individual has may set limits on her ability to choose a service, or provide her with sufficient freedom to select whichever service she desires. In the U.S., health insurance is largely private and thus combines with an individual woman's financial means to determine her ability to choose among services, i.e. her ability to pay beyond the coverage of the health policy she has. A number of insurance policies provide limited or no maternity coverage. This puts women with comparable financial means in different positions regarding their ability to actually pay for their care, depending on the health care coverage they have. Certain types of health programs limit their coverage to their own facilities, such that when an outside service is chosen the care provided there is not covered by the insurance policy. For example, HIP has its own clinics and hospitals. Its users have to consider the possibility of paying out-of-pocket for prenatal care and childbirth, including the possibility of emergency hospital care, if they opt for use of a non-HIP service. Obviously, the better the financial situation of women, the more freedom to choose they have. Sometimes women simultaneously use more than one prenatal care service. One such case is of women who opt for homebirth but are required, or prefer, to also see a physician during their pregnancy for backup purposes. Medical insurance does not always provide coverage for this double-use of services. In comparison to other Western countries, especially those where the health care system is in public hands, the American system limits freedom of choice from the financial respect. Yet it

should be kept in mind, that while financial limitations may be largely nonexistent in public health systems, other contextual limitations on freedom of choice may exist. For instance, a centralist system may impose one set of regulations on the nature and management of all services to the point of eliminating variability and thus also a sense of choice. One possible factor affecting the nature of such regulations and the general tendency toward uniformity among health care services is professional philosophy. It affects the actions of professional organizations and the implications of such actions on services. In this respect, the fact that the American health care system is largely private helps in increasing choice for women, in that it allows the establishment of various services.

Professional organizations have also established rules that affect the degree of freedom of choice women have regarding who they can use to assist them in prenatal care and childbirth. In New York State lay midwifery is prohibited, and nurse-midwives can only practice in cooperation with physicians, a situation that may pose limitations but also freedoms on women's choice ability. Women having certain medical and physical conditions can only be treated by physicians. Close cooperation of midwives with physicians may thus result in ways of dealing with complications that differ from the expectations and desires of users, who may object under all circumstances to the involvement of physicians in their care. An establishment such as the Maternity Center Association (MCA), where the core of attendants are midwives, has to screen its patients carefully and reject those who already have physical conditions that they cannot care for or who develop them during pregnancy. Liberal care by midwives, meaning refraining from medical interventions in labor and birth, is another possible outcome of their connection with physicians. They may be more confident in the care they can give to a patient with complications without having to leave her in spite of development of medical complications.

Professionally determined limitations on types of care, also resulting from professional philosophies, are common to the U.S. and some other Western countries. A basic trend toward maximum hospitalization for childbirth underlies the screening process common to both the U.S. and England in spite of the existence of out-of-hospital services in both countries (Kitzinger & Davis, 1978). In other European countries screening for such services is in existence but is less stringent, stemming from a perspective that is less influenced by the medical model of childbirth as sickness and inherently dangerous (Ashford, 1986; Nash & Nash, 1979; Wertz, 1983).

Some extreme instances that occurred recently exemplify the extent to which contextual structures have become powerful societal powers, involved in individual women's decisions about themselves and their unborn babies. Recent tendency to see the unborn fetus as a patient with rights and as separate from its mother has lead to pressures put on pregnant women to select places for childbirth that were not their choices but which were perceived by others as better than the birth setting the woman opted for (Katz-Rothman, 1984). In the past such cases involved women who opted for homebirth and who were forced to use hospitals and to undergo cesarean sections for the baby's sake, yet against the mother's will.

In the practical realm, there are limitations to the choice that stem from rules set up by maternity services themselves to decrease or eliminate altogether American women's ability to select and reselect services. Making choices of services past the fifth month of pregnancy, or attempting a change of service at that stage, may face women with a largely limited range of services. This is because most services do not accept patients beyond this point in time, and insurance coverage may also be jeopardized if use of services is done too late.

In an attempt to examine the various ways contextual structures could influence decision making, this research included women who were covered by different types of medical insurance policies, among them both users of midwives and of physicians. Several had physical and medical conditions that had implications for their choices.

Decision Making Processes

The above review stressed the limitations many women face in choosing maternity services. Indeed, it has been argued in the past that in spite of the existence of alternative birth settings, women really do not have much choice (Richards, 1982). This view implies that no choice process is involved in the selection of a service for prenatal care and for birth. Yet the birth reform literature is abundant in accounts and recollections of women's experiences of choice for their maternity care (Ashford, 1984; Gilgoff, 1978; Lee, 1986). It includes discussions of alternative settings for childbirth and ways to use them in spite of structural limitations (Stewart & Stewart, 1976) and overall reveals that the choice of place and attendant has a high priority for women. From Ashford's (1984) collection of birth stories it is evident that even as early as the beginning of this century, and later on, women have given much thought and consideration to their choice of place, attendant and type of service. Also, many women clearly have specific preferences for their births which they are willing to actively seek, and in order to achieve them make repeated choices and change in their services of care, in a lengthy complicated process.

The importance of choice of service for maternity care is emphasized by writings in various disciplines. The anthropological literature emphasizes issues of conformity with cultural norms that are crucial for social acceptance and participation in various cultures (Auerbach, 1982; Jordan, 1983; Kay, 1982; McClain, 1981). According to these writings, many women would opt for services that are considered the norm in their cultures,

regardless of their own desires. These writings deal primarily with the choice between traditional homebirth services, with midwives who may or may not have formal education, and that of medical services in hospitals.

A historical perspective reveals that the choice of service for childbirth was deemed important to American women for various reasons since the late 19th century (Wertz & Wertz, 1979). Desire to control the pain and thus have a pleasant birth experience was reflected in women's opting for physicians and facilities that offered anaesthesia during childbirth, a process that started in the second half of the 19th century. Women began to see the hospital as safer than the home for childbirth, as medicine advanced and was perceived as offering women more than midwives did. Edwards and Waldorf (1984), on the other hand, suggest that homebirth services that existed in the early 20th century in Chicago offered women more safety than hospitals, because of the spread of infections in these institutions, especially when city hospitals were concerned and the care was given to low-income women. According to Leavitt (1980), women who desired to gain control over the process of childbirth saw a way to gain it in the use of a combination of scopolamine and morphine known as "twilight sleep", as a way to gain it. The fear of death in childbirth, which according to Shorter (1982) was prevalent where ill-trained midwives and physicians practiced, made women turn to the care of physicians that were properly trained and who practiced in modern, well-equipped hospitals. Fear of death in childbirth as the motive in women's preference of the hospital over home and of physicians over midwives for their maternity care is also pointed out by Dye (1980) and Leavitt (1984).

Literature about the current choice situation of services for pregnancy and childbirth in the United States links the importance of the choice to women's desires for a certain type of experience and care. It is when avoidance of surgical and other invasive procedures

such as excessive testing during pregnancy, and cesarean section or episiotomy, among others, is deemed important, that the choice of service becomes salient as well (Brackbill, Rice & Young, 1984; Cohen & Estner, 1983; Keyser, 1984; Kitzinger & Simkin, 1984; Korte & Scaer, 1984). A question this study attempted to answer was whether the choice was indeed more important to those who had specific and nontraditional desires in mind, than to those with traditional preferences.

The importance of having a pleasant childbirth experience, to satisfy emotional and spiritual needs of women and couples has also been stressed in the literature (Peterson, 1981; Sousa, 1976). Most of these writings emanate from the birth reform movement of the past 15 years, and often reflect the perspective of people who wanted to avoid mainstream American medical ways of pregnancy and childbirth management. They present homebirth as the most desirable alternative. This literature lacks, however, the perspective of individuals, for whom the choice of service for pregnancy and childbirth is important yet who confront structural limitations of the types discussed above. For example, the process of choice for women who are considered "high risk" by the medical establishment and as such are rejected by midwifery services, or those who desire the care of nurse-midwives yet lack insurance coverage or the financial means to pay for such care, are all missing from it. Also, most of the literature stems from the same tradition of reform in the mainstream or traditional medical way of childbirth management. While claiming to speak on behalf of all women, they do not represent well the perspective of those with the opposing views. A basic assumption underlies these writings, i.e. that all women uniformly have the same desires for their care, such that they do not allow for individual variations and conditions. The result is a misleading picture in which all women are seen to desire out-of-hospital births. Women who do not categorically object to cesarean sections, who see hospital policies as beneficial though not necessarily comfortable, and who do not favor midwifery care, are hardly represented at all in this literature. For that

reason, the present study attempted to include a variety of perspectives of women who opted for progressive as well as traditional maternity care.

The Decision Making Process in Prenatal Care and Childbirth

The choice of prenatal care and childbirth service thus involves for most women an active decision-making process although one which is framed by professional, insurance and organizational limitations. To understand this process it might seem reasonable to approach it from the framework of decision-making theory. Traditional research and writings about decision-making were examined but discovered to be unsuitable in providing a theoretical and conceptual framework for this research. Most of the studies were designed as laboratory experiments, where subjects (usually students receiving course credit for their participation) performed tasks of preference (often perceptual in nature, e.g. Pitz & Sachs, 1984). This body of research is unsuitable for informing the present study for several reasons. First, laboratory experiments are short, and as such can hardly resemble the process people undergo when they have to investigate alternatives and choose among them. Second, the nature of tasks cannot tell much about choice in real life situations, when people are not necessarily presented with all the information at once or at all, and when their choice has implications for their lives. Third, students participating in a laboratory experiment will not bear the consequences of their choice, a situation that may have an effect on the way they make them. The scope of the problems people are faced with in real life and the complex combinations and interactions of contextual forces with individual situations make it impossible to reduce real life decision-making to simple laboratory tasks. The location of the research, be it in a laboratory or in a particular place in the field, influences their perception and the way the problem in them is addressed by respondents. This, in part, is the reasoning behind the environmental psychological approach to problems, which requires that they be dealt with in the context in which they appear in life (Winkel, 1983). Finally, decision-making research traditionally has focussed

on the cognitive aspects in the choice and neglected the emotional aspect involved in it in real life. Thus, knowledge gathered through laboratory research cannot serve as the basis for knowledge about crucial real life choices.

One of the issues missing from laboratory research, and which seems to be a crucial part of decision-making in real life is a focus on the process leading to the choice rather than on its product. Indeed, dissatisfaction with traditional theorizing and research on decision-making led several writers in the area to advocate a focus on the process involved in it rather than on product (Wallsten, 1980), especially when dealing with real-life decisions with significant consequences for individuals (Janis & Mann, 1977). It was suggested that research methods that focussed on the choice be replaced with process-tracing techniques, to explore both the mental processes as well as the practical activities of individuals during the choice.

One theory that attempted to accomplish this was Janis and Mann's (1977) conflict theory of decision-making. It was developed primarily to examine decision-making when real life crucial choices had to be made, such as career choices or decisions that are involved in policy making. Several aspects of the theory, however, make it unsuitable as a framework for the study of choices women make of childbirth services. A basic assumption in Janis and Mann's theory is that available alternatives are not only incompatible but also in conflict with each other, and are perceived that way by the decision maker. However, it cannot be assumed that women perceive their alternatives in this way, and indeed a basic question in the study concerns the nature of these perceptions. They may see them as different, or perceive the issues underlying them as not incompatible with each other, thus the choice does not necessarily imply conflict settlement. Another aspect of this theory which makes it unsuitable for the choice of a prenatal care and childbirth service concerns the availability of knowledge at the time of decision making. The theory

assumes that knowledge is available about alternatives, and that the decision maker is involved in information pursuit for the achievement of this knowledge. However, in the situation of women choosing services for prenatal care and childbirth not all the information necessary for the choice is available at the time a commitment to a service needs to be made, around the 5th month of pregnancy. Moreover, women may differ in their desire to seek knowledge about services and about the conditions of pregnancy and childbirth, thus their preferences may not be sufficiently clear to them at the time of choice. These two issues, i.e. the availability of relevant knowledge and the tendency for its pursuit, are important to this study for the understanding of the context of making the choice of service and thus are discussed below in detail. Yet a general note should be made regarding the usefulness of providing knowledge about alternatives. As Katz-Rothman (1984) argued, having more knowledge may not necessarily increase women's freedom of choice, but rather may lead to feeling, or actually being pressured to make the "right" choice according to a criteria that is foreign to the individual and does not necessarily reflect her own preferences.

The literature does not provide clear findings about women's information pursuit. Mather (1980), who interviewed women after giving birth, found that they were interested in knowledge about childbirth alternatives. However, findings are not clear regarding pregnant women. McClain's (1983) finding that early in pregnancy women do not know what they wanted for their birth may result from the fact that a major information source -- childbirth classes-- is only available toward the end of pregnancy, of from their own lack of motivation toward independent information pursuit.

Childbirth preparation classes are expected to provide information about the care women can expect to get. In the New York metropolitan area many such classes are offered by the services themselves (e.g. hospitals, the MCA), as well as by other organizations and independents. As a source of knowledge to aid in the choice of service

these classes are rarely suitable, as the vast majority of them are given for women approaching the end of their pregnancies, and thus well beyond the point in time when change of service is possible. Also, the value of information about services and their policies of birth management given in such classes that could potentially aid in decision making is questionable. Women who opt for an institutional birth often take classes sponsored by their institution, getting preparation for the procedures they will encounter there. But the amount and type of information provided by these sources is general and limited. Regardless of what is communicated in the classes, the sponsoring institution tends to reserve the freedom to decide on the nature of complications and the way to handle them, when they arise. Thus, in the classes women can only obtain general knowledge about the course of labor and its management when uncomplicated. These preparation courses have been criticized for not preparing women for the complexities of labor and for the real pain involved in childbirth, by using general and even misleading terminology (e.g. by referring to "discomfort" or "intense" sensations during labor instead of to pain), thus increasing women's fears (Kitzinger & Davis, 1978; Stewart & Stewart, 1976).

Attendants would seem to be a primary source of information, yet whether they actually provide it depends on their personal and professional inclinations and on the nature of their relations with patients. Physicians, trained to be the decision makers, tend not to share much information with their patients and do not encourage asking questions (Katz, 1984; Oakley, 1980; Roberts, 1985). Nelson (1981) reports that women who felt that they had had clear desires and had inquired about them, still found out later a gap between the care they expected and actual reality, since during labor and childbirth their attendants, all of whom were physicians, disregarded patients prior requests. The concept of "birth plan", a list of desires and possible ways to handle childbirth to be decided and agreed upon by attendant and patient was recently introduced (Brackbill, Rice & Young, 1984) yet physicians, who stress the necessity of patient trust in attendants, have expressed negative

views about it (Klein, 1983; Hertzberger & Potts, 1982). From anecdotal writings it seems that midwives tend to provide more information to patients about their services and policies earlier on in the pregnancy, to aid in decision-making. The MCA in New York has an orientation meeting for prospective users, in which oral and written information is disseminated, and visitors can raise questions about care. They are also taken on a tour of the premises. Similar policies exist in several midwifery practices affiliated with hospitals. While women who inquire about these services probably benefit from such attempts to provide information by the services, the question is whether those who do not have the initial knowledge about midwifery services, have a way of getting such knowledge. In other words, while these services provide information at the time of decision making, the receivers of the information are women who already have at least some knowledge about these services. The question of interest in this study concerns the source for such initial knowledge among the women who get to the services of their choice at all, and about the initial knowledge of others, who do not get to such services. "Informal" sources of knowledge may play a role in supplying women with the initial knowledge they use for their choices.

The existence of a mental structure, a subjective reflection of the outside world related to an individual's activities, has been hypothesized by theoreticians from various traditions. Boulding (1956), an economist, coined the term "images" for such structures, suggesting that they include individuals' accumulated knowledge about the world and themselves in it, and that they can aid in the initiation of activities. The contents of these images, according to Boulding, have been gathered through experience and also through direct and indirect absorption of information. Environmental social scientists have studied the image construct extensively, mostly as it refers to the physical environment, thus referring to "spatial images" (Downs & Stea, 1973). The relationship between spatial images and activities has focussed primarily on spatial behavior, such as way-finding

(Downs & Stea, 1973; Windsor, 1981). Experience has been assumed to be a major factor in image formation (Lynch, 1960). Indeed, immediate experience was found salient in studies of spatial and other images (Baldassari, Lehman & Wolfe, 1986; Wofsey, Rierdan & Wapner, 1979), yet it was also pointed at as potentially interfering with the imagination of alternatives to existing environments (Davidoff & Reiner, 1962).

It is the general concept of the image as a volume of knowledge about the world and an aid in initiation of activities, that is of interest in this research. It is assumed, that women have images of various entities related to childbirth and related experiences, including pregnancy, attendants, settings for childbirth, labor and birth. Such images, which presumably consist of knowledge acquired through perception and direct or indirect experiences, may by involved in the process of maternity service choice. Because of their previous experiences, women in their second pregnancies probably have images that are more concrete than those of women in their first, because of. Indeed, the choices of women in subsequent pregnancies have been found to be influenced by their experience (Kitzinger, 1978; Mather, 1980). The role of experience in the image of childbirth-related entities will be examined here, through inquiry into images of both women in first pregnancies, who had not experienced the whole cycle of pregnancy and childbirth previously, and women in their second, who had.

Lay referral systems based on social networks, and doctors' references have been found most valuable in seeking information about health care services and in "doctor shopping" behavior (Mather, 1980; Wolinsky & Steiber, 1982). Also, books and films about childbirth are now available as well, providing information on a range of childbirth options and procedures, including Cesarean-sections, homebirth, hospital birth etc. (e.g. Bean, 1982; Gandon, 1985; Wolfe, 1981). It is questionable, however, whether women are exposed to these information sources by the time of decision-making.

The study of an individual's decision-making cannot ignore its structural and psychological aspects. Theoretical approaches to decision making were not found satisfactory in that they do not consider real-life aspects of the choice process. Yet without their inclusion in the study of the choice process the intricacies of the situation in which women make their choices cannot be fully understood, nor can their actions.

Services for Pregnancy and Childbirth

A maternity service consists of a person to provide care during pregnancy and to attend and assist at the time of childbirth, and of a place where the birth occurs. It is the combination of the person and place that constitutes the service that women opt for. Yet the degree of connection between them on structural and formal levels may vary.

In the U.S., among women who are privately insured, it is being a patient of an attendant that puts the official stamp on the choice of service, regardless of whether the choice of service starts from or focusses on the place for childbirth. This probably influences women's perceptions of their chosen services, which may become represented primarily by the attendant from whom they receive prenatal care. An exception may be the MCA, where women are patients of the institution, not of individual midwives, and which may also be perceived as one unit that is not separable. The terminology used here was selected in an attempt to reflect the fact that while a service as a whole was formally selected, issues related to place and attendant that comprise this service were examined separately, the way they were perceived by women.

Pregnancy and Birth Attendants

All practicing obstetricians in the New York metropolitan area are affiliated with hospitals. There are several independent midwifery groups, also affiliated with hospitals; midwives are the main attendants at the MCA, where they practice with a few physicians providing backup services when complications occur. Several midwifery practices offer homebirth services in the five boroughs, and there are several more located in neighboring areas (on Long Island, in Westchester and in New Jersey). Most of these are nurse-midwives, since lay-midwifery is not legal in New York State. Respondents in this study were patients of all the above types of practitioners.

Shorter (1982), in his historical review of the development of obstetrics and midwifery, concludes that drawing a difference between the professions merely on the basis of gender and professional training is too simplistic. Rather, he suggests that t is the quality of education and care given by individual attendants that need to be evaluated. While subtly justifying the superior status physicians have enjoyed historically over midwives, Shorter recognizes different levels within each profession. According to him, the well-trained practitioners included both midwives and physicians, mostly concentrated in and around urban centers, while those in both professions located far from these areas provided inferior care. A different opinion is presented by Ehrenreich and English (1973) who provide a feminist orientation, according to which midwives provided care that was superior to physicians', especially when the latter lacked the necessary formal training and practical experience. Wertz and Wertz (1979) seem to agree with both opinions, stating that while midwives did have the knowledge and ability to deal with normal childbirth better than physicians, they were shunned from the developing educational institutions and barred from using advancements helpful to women, but which were kept in physicians' hands. Consequently, physicians' expertise increased, especially in the care of complicated births, while those of midwives remained largely in the realm of uncomplicated ones, resulting in the unjustified perception of midwives as inherently incapable of handling anything beyond routine and uncomplicated childbirth. The historical tension between the professions is still evident today in the tight control medical boards place on midwifery practice and in its strong opposition to lay midwifery.

Professional differences in perspectives on pregnancy and childbirth exist between midwives and obstetricians. Physicians in general, obstetricians included, are trained with an emphasis on the abnormal and on intervention (usually medical or surgical) (Harrison, 1982; Scully, 1980). Midwives, on the other hand, are trained to "let nature take its

course" and with an emphasis on the variety of normalcy and on the avoidance of interventions (Katz-Rothman, 1983). This difference has profound implications for the ways physicians and midwives view and handle pregnancy and birth. For example, while physicians usually place time criteria on the length of stages of labor, resorting to medical and surgical interventions in cases of deviation from it, midwives are willing --as long as no complications arise-- to let each labor progress at its own pace (B. McDonaugh, personal communication, March, 1986). There are differences in professional philosophy between the two types of practitioners, reflected in different practices and policies regarding handling of pregnancy and labor. An important representation of this concerns relations with patients. Physicians do not place emphasis on their relations with patients as much as they stress the provision of sound medical care, while for midwives the establishment of relations with patients is an integral part of their overall care. Physicians thus enlarge their practices, limiting the time they allot for each patient, while midwives keep the number of patients at any time to no more than what they can handle, and still remain within their criteria of quality care. As a result, obstetrical patients receive less personal attention and time with their attendants, during both prenatal care visits and birth, than do midwives' patients (Arms, 1975; Oakley, 1980).

Relations of women-patients with attendants. Most of the relevant literature deals with relations between women patients and doctors (Notman, 1978; Oakley, 1980; Roberts, 1985). Relations of midwives with their patients have been studied less, and most of the known material is in the form of personal recollections and reflections (Arms, 1975; Ashford, 1984; Lee, 1986; Leeson & Gray, 1978).

Women in general have been considered one of the "difficult patient" groups in their encounters with medical professionals (Roberts, 1985), especially those who ask questions about their care: "As a group, the women described as 'difficult' were characterized as

highly anxious with a strong need to be in control, especially in decision making situations" (Kahan & Gaskill, 1978, p. 261). This may lead to tension-ridden relations, since physicians are trained to be in charge and make judgments and decisions, not to share information and power with patients (Katz, 1984). As Oakley (1980) found, during prenatal checkups physicians did not even view women as credible information sources regarding the basic information about their childbearing history. Asserting the importance of trust in doctor-patient relations during the childbearing year, Klein (1983) claims it is women who do not trust their doctors. Yet, Roberts (1985) found that women tend to believe in doctors and their judgment and in many cases do not openly question them.

The impression from women's personal recollections of their relations with midwives (Ashford, 1984; Lee, 1986) is that these are usually warm and open, and patients are respected and trusted as reliable information sources. Also, midwives tend to provide information and share with women the decision making regarding their care (within certain limits, which are clarified from the start), more than in the case of physicians. In general, midwives attempt to follow their patients' desires regarding the nature of care (Arms, 1975).

Hertzberger and Potts (1982) stress that it is important for the quality of prenatal care that patient/attendant are open and trusting. Indeed, based on recollections, women who felt the need to influence the course of their care, have included adequate and trustworthy relations with attendants as part of their needs when they sought a maternity service (Ashford, 1984). Yet the evidence is scanty, and does not include investigations of relations with both physicians and midwives and their role in women's choices of services. A comparative look at relations with both types of attendants, and the place of these relations in women's service choices, were included in this research.

Review and Comparison of Settings

In the New York metropolitan area childbirth can be planned to take place in institutional settings inside and outside hospitals, and at home. Hospitals provide clinic services, serving mostly low income women. There are both teaching and community hospitals in the area. The former are affiliated with medical schools, and the care of their patients is partly in the hands of students at different points in their training, in addition to regular staff, consisting of physicians and nurses, while community hospitals ordinarily have only private physicians and nurses in staff but no students. They are also smaller in size than teaching hospitals. Hospitals in general vary in their policies regarding the management of labor and birth. Out-of-hospital birth can take place at the MCA, a free standing birthing center, or at women's homes. Although what follows is a review of places for childbirth, it should be kept in mind that the physical place turns into a setting with its own rules and regulations which cannot be ignored. Moreover, similar settings with different types of attendants provide different care. Thus, the physical place and policies must be taken into account together with the attendants practicing there, to evaluate the type of service and the nature of care it provides.

The meaning of service choice. Since the choice of a service includes selection of both an attendant and a place for childbirth, it must take into consideration the unique characteristic and combined philosophy and policies of both. An example for the inseparability of the human and physical factors in services is the evaluation of physicians affiliated with hospitals. Physicians are bound by hospital regulations concerning the handling of certain situations, regulations resulting from economical, medical, or insurance-related factors. Similarly, the hospital cannot be valued on its own merits; it is the combination of whatever the hospital offers and the individual philosophy of the attendant that actually determines the nature of care. For example, many hospitals have

added birthing rooms to their facilities as part of the labor--delivery unit, or elsewhere on the hospital grounds. Yet the use of these facilities depends on the preferences of individual practitioners, many of whom adhere to traditional philosophies of labor and birth management, resulting in underuse of many such birthing rooms. On the other hand, policies and physical environment also interact with desires of individual practitioners. The absence of an established birthing room does not mean that the hospital follows traditional philosophies regarding birth, since many hospitals allow birth in the labor room, which functions according to the philosophy of a birthing room and is more pleasant than a delivery room. It is the philosophies and the leeway left for for individual attendants to choose their own way of practice that contribute to the nature of care in a specific service.

Hospitals

While all hospital births have certain aspects in common (Arms, 1975), there are variations that depend on the specific institution in question. In the hospital, childbirth is considered a medical event, and is managed as such (Cohen & Estner, 1983; Rosengren & DeVault, 1970). Interventions like IV and episiotomy are routinely done; women often are given drugs to hasten their labors and reduce pain; they are moved from one space to another (labor room-delivery room-recovery room). In many instances women are on their backs with their legs up in stirrups when they give birth. Indications for complications and emergencies during the course of labor and birth are usually judged as such based on technological equipment (e.g. electronic monitors) and are dealt with by other interventions such as amniotomy or Cesarean sections (Young, 1982). Birth attendants in hospitals are medically trained and licensed (physicians and nurses). In most area hospitals the laboring woman's partner is allowed to stay with her throughout her labor and delivery, including cesarean sections.

Many hospitals now offer the option of using a birthing room, where women spend all three stages of labor and birth (i.e. labor, birth and recovery periods). Yet as already discussed, the use of this option depends on each woman's physician's preferences; while some allow or prefer it, others would rather have their patients deliver "traditionally", i.e. in the labor, then in the delivery room. While most hospital deliveries are done with an obstetrician in charge (although during most of the labor hospital nurses stay with the birthing woman, the physician appearing only toward the birth itself), there are several nurse-midwifery practices affiliated with hospitals. They usually use birthing or labor rooms for uncomplicated deliveries, where they are in attendance. The location of the birthing room on hospital territory and its proximity to the regular labor and delivery suite affects attendants' practices in it. While the use of these places for childbirth has started with the aim of providing progressive care, avoiding unnecessary interventions, proximity to traditional facilities and equipment contributed to reliance on equipment of the regular labor facility, resulting in an increase in the rate of transfer out. As DeVries (1980) concludes, not much of their original objectives was left in most "alternative" facilities located on hospital territory.

Hospitals are institutions and as such have policies and regulations that aim at the welfare of all their users, patients and staff alike (Starr, 1982). Yet the needs of the two groups may contradict at times, often resulting in policies that aim at enhancing the welfare of one group at the expense of the other. Hospitals' proclamation that their goal is of primarily serving patients is sometimes exercised in ways that conflict with the latters' well being and comfort (Anderson & Gevitz, 1983). The institutional qualities of rigidity and overlooking the needs of individual users, identified by Rivlin (1977) apply to hospitals, as found by Cohen (1980). Kirsners and Waters (1972) and Taylor (1982) provide reviews of patients' conditions in hospitals which reveal the limited control they have over their bodies, possessions and care. Patients have traditionally been expected to undertake a

submissive patient role that implies acceptance of the status and power differences with doctors, without questioning or challenging it. Several medical sociologists have formulated descriptions of the patient role that revolves around the theme of submissiveness and acceptance (Bloom & Wilson, 1978). Taylor's (1982) review also examines patients' ways of demonstrating resistance to their tight control by hospitals and doctors. She outlines the "good" (helplessness, submissiveness) and "bad" (questioning, demanding information, anger) patient behaviors, and concludes that they are both reactions to the depersonalization of hospital conditions and to the lack of control over care. She recommends to give patients control over a peripheral aspect of their care, a practice that has proven in the past result in more cooperative behavior and a successful treatment and neglects to discuss ways to involve patients in the central decisions regarding their treatment. The "consumerist" patient approach (Haug & Lavin, 1981) has been studied and presented as the antithesis of the traditional passive patient role. In the consumerist approach, patients demand information about their condition and of alternative courses of treatment, and to take part in decisions of their care. This is an active patient role, as opposed to the passivity characterizing the traditional patient role as formulated by Parsons (Bloom & Wilson, 1978).

A close examination of the literature on hospital birth in America reveals that hospital ways of labor and birth management often do not aim at enhancing the comfort of individual patients but of hospital workers and routines, as pointed by Rosengren & DeVault (1970). They found in their study of a hospital obstetrical unit that the spatial and temporal organization of work routine were often adhered to through the use of interventions, mostly anesthesia and forceps. By the use of such procedures, labor and birth could be slowed down or accelerated, according to the predetermined schedule of work that staff members had set for themselves, and for the orderly utilization of subunits such as the labor and delivery rooms. The well being of mother and baby, for whom

routinely applying these interventions may be harmful when unnecessary, is often superseded by hospital convenience (Richards, 1978). Among such potentially harmful interventions that are done routinely is amniotomy, performed to hasten labor in a "natural way", i.e. without drugs (Simkin, 1982) and episiotomy, a surgical procedure done in some hospitals on almost all patients in their first births, and which may lead to prolonged pain and infections (Kitzinger & Simkin, 1984; Thacker & Banta, 1983). These procedures have in common their original aim, i.e. the aid of women with complicated labors that needed to be hastened. However, because of the predictability they offer and their ability to shorten the duration of birth, have become routine in labor and delivery suits.

The availability of technological and other equipment has led to two trends in childbirth management among physicians practicing in hospitals. One trend is toward increased use of medical interventions in labor and delivery, which characterizes the majority of hospital practitioners, the other is its avoidance as much as possible, preached and practiced by a minority of physicians. Both trends are based on the assumption that if something went wrong as a result of childbirth management, the "safety net" of the hospital, i.e. its equipment and staff, are there to correct errors.

Out-Of-Hospital Institutions

The Maternity Center Association (MCA) is the only free standing birthing center in New York City. It provides care for pregnancy and childbirth by nurse midwives, practicing in close cooperation with physicians affiliated with several city hospitals (Lubic, 1976). Screening for so-called existing or potential medical complications (e.g. age, multiple pregnancy) is done according to strict criteria such that only "normal" pregnancies and deliveries are handled there. An attempt is made by the institution to provide ample information about its services to prospective users early in pregnancy. During birth, there

is an emphasis on minimal intervention, and the only medications used are pain killers in small amounts. Women in labor are given the freedom to walk around, eat, or be involved in other activities that are relaxing to them. A large shower is available for their use during labor, as is a kitchenette. The number of people that can be present in the birth is not rigidly limited, and children can also be present, provided that an additional adult is present to supervise them. When indications for possible complications appear, women usually are transferred to hospitals where back-up physicians handle the rest of the pregnancy and/or birth.

The MCA is similar to hospitals in having its own institutional policies regarding the management of childbirth itself, though these are more liberal and sometimes flexible compared to hospitals'. One cannot ignore the social and political context in which such a setting operates. The place and its practitioners are all at the mercy of licensing boards, controlled mostly by medical people. Deviation from acceptable management of labor, especially if ill-fated, can lead to a loss of license to practice and/or an increase or cancellation of professional insurance. Thus, practitioners in such "alternatives" to the institutional hospital setting still are limited in the extent to which they can allow women to share in decisions of their care.

Homebirth Services

Homebirth services in the metropolitan area are given by both lay and nurse midwives, who provide care for pregnancy and childbirth. They have the backup of other midwives, physicians and hospitals for aid in emergency or complicated situations. Several have their own screening procedures for potential complications in pregnancy and birth, which are similar to those used by most midwives affiliated with hospitals. For example, women with multiple pregnancies are not acceptable, as are women who suffer

from medical conditions defined as potentially or actually "high risk". Women who use these services are usually required to be under the care of physicians for back-up purposes.

Using a homebirth service also entails an agreement with a certain way of birth management. By choosing a specific midwife for a homebirth, a woman agrees to the procedures and decisions of that midwife (for example, regarding the existence of complications). If a back-up service is used as well, as is usually the case, one must also comply with that service's procedures.

Issues in the Analysis of Birth Settings and Procedures

The choice of a service for pregnancy and childbirth care is analyzed in literature that focusses on processes and developments occurring recently, during the past 15 years or so, and between the middle of the 19th century and the 1930s. The latter is important to the understanding of the choice issue, as it was around that period that two major changes occurred in the history of childbirth in America: medical people, mostly men, replaced female midwives and became the birth attendant of choice for people who could afford to make such choices, and birth was gradually moved from the home to hospitals (Devitt, 1977; Wertz & Wertz, 1979). By the 1930s, the majority of births took place in hospitals. During the past 15 years or so, a demand for change in childbirth care practices was raised by the Birth Reform movement, which includes various groups of concerned lay people, attendants and scientists. The same issues raised historically in reviews of the events that led to the changes in American practices of childbirth are being raised in the debate of recent years' developments, concerning current settings and practitioners. The three basic issues are physical safety (the prevention and treatment of maternal and fetal/baby mortality and morbidity); control (who makes the decisions?); and the emotional quality of the birth experience. Depending on the beholder, one of them takes priority.

Safety. Historically, the hospital has been presented to women by advocates of the medical way of childbirth management as a safer place for birth than their own homes, with regard to physical injuries to mother and baby (Devitt, 1977; Leavitt, 1984; Wertz & Wertz, 1979). With the use of hospitals, women were also told it would be safer to use physicians over midwives for their deliveries, since the former had formal academic education and the latter were pictured as dirty and uneducated (Ehrenreich & English, 1979; Shorter, 1982). Currently, the safety argument is used primarily with regards to fetal and infant's well being, not so much the mother's, and cases have been documented where women who refused to use hospitals for birth, based on a perception of safety which differs from the medical opinion, were sued by self-appointed advocates of the unborn on grounds of child abuse (Brackbill, Rice & Young, 1984; Hubbard, 1984).

Recent debate of the safety of hospital birth management procedures led to investigations of the ways they are employed and their potential benefits and hazards to patients. Certain procedures, generally but not exclusively those based on technological developments, have been identified as risky and harmful, especially when used routinely. Among these are the surgical procedures of episiotomy and Cesarean section (Keyser, 1984) and use of electronic fetal monitors and ultrasound (Brackbill, Rice & Young, 1984). Similarly, other interventions designed to speed up labor and reduce pain (drugs such as Pitocin and Demerol) were also found potentially harmful to mother and newborn (Brackbill, McManus & Woodward, 1985). All of these have been developed for diagnosis and handling of complications yet their routine use (or almost so) in many hospitals can be physically and psychologically harmful to mother and baby when unwarranted (Young, 1983). Other procedures of hospital care with none or questionable benefits were identified as well. The hospital procedures of separation of mother and baby immediately after birth and scheduled feedings have been found harmful to the

establishment of maternal-baby relations (Peterson & Mehl, 1978) and of lactation (Cohen & Estner, 1983). High-tech intensive care for disabled newborns in hospital nurseries, hailed as a most beneficial and unquestionable improvement of hospital care, has been challenged from the point of view of the infants themselves and their families, as well as that of society at large, on ethical, social, psychological and economic grounds (Lyon, 1985).

The decrease in fetal and maternal deaths in the past 50 years was not found to result from developments in technology and knowledge, as advocates of hospital birth argue. Rather, they are the consequence of general improvement in sanitation and nutrition (Devitt, 1977). Comparisons between hospital and homebirth suggest that mother and baby stand a lower risk of physical injuries birth outcomes (mortality and morbidity) at home than at the hospital (Kitzinger & Davis, 1978). In the hospital, mothers and infants are exposed to infections that do not occur in the non-sterile home (Edwards & Waldorf, 1984). Such findings have been used to justify calls for minimization of some procedures and the elimination of others. In addition, alternative settings and services for childbirth have been advocated and created in which interventive procedures are used with caution or are eliminated altogether. The hospital, it was said, is safe for the 5 to 10% of complicated births, when its benefits outweigh the hazards of its routine use of interventions for uncomplicated births.

Consumers' definition of risk may differ from that used by advocates of mainstream obstetrics. To some people, the hospital is perceived as unsafe for handling pregnancy and birth, due to the spread of infections in it and to the likelihood of other possible iatrogenic injuries occurring there (Mehl, Peterson, Shaw & Creevy, 1975). They would prefer an out-of-hospital setting or reject institutional birth altogether and choose their own home. For others, the hospital, due to the availability of sophisticated

equipment and knowledge in it, seems the safest possible setting for childbirth. Beliefs regarding medical risk and safety were found to be strongly related to the choice of settings for childbirth (McClain, 1983; Sacks & Donnenfeld, 1984). Yet in contrast to the belief of hospital birth advocates, physical safety in general is not always the most important consideration in the choice of childbirth services (McClain, 1981). Various other factors may be more salient to women in weighing the alternatives and the risks inherent in them. Issues related to the loss of privacy, loneliness, adherence to social customs regarding handling the baby and the like are some additional concerns. The choice of setting for childbirth may be influenced more by these considerations than by the medical risks it may carry.

Although most of the studies documented physical effects of medical hospital birth management techniques, some focused on the psychological impacts they have on mother and baby. The fallacy of focussing only on mortality and morbidity statistics while ignoring the psychological well-being of mother and baby has been pointed by Oakley (1983), who called for a reverse in focus of childbirth studies. The issue of the quality of the childbirth experience has become part of the debate about childbirth management techniques.

Comfort and the fulfillment of emotional needs. Shorter (1982) suggested that medical progress rid women from fear of death in childbirth, thus giving way to the recent concern over the childbirth experience. Oakley (1983), an advocate of emphasis on psychological needs of women in gynecological and obstetrical care, calls for an elevation of these needs to the same level of importance and consideration as physical needs, based on these very advancements in maternity care. Indeed, there is agreement in the literature about the discomfort associated with hospital birth.

The home has been presented as offering a superior childbirth experience, compared to the hospital (Arms, 1975; Gilgoff, 1980; Sousa, 1976). Kitzinger (1978) found that British women opted for homebirth in second births out of rejection of the hospital option and as a result of having had negative birth experiences there the first time. McClain (1981) suggests that emotional fulfillment may be the reason for some opting for homebirth, while for others the hospital represents a ritualistic passage across life stages and is not necessarily perceived primarily and negatively as a medical institution. Philosophical reasons were identified in another study of homebirths, where couples rejected consciously the medical way of childbirth management out of concern for total quality of life (Hazell, 1975). Auerbach (1982) identified a consideration that she labeled "emotional support/humiliation-anxiety" that was most important for women choosing between hospital and homebirth. It was related to fears of loss of privacy and of social network support in an unfamiliar situation. Similar findings by anthropologists are presented where the choice of place represents to a large degree a desire to fulfill emotional needs (Ashford, 1984; Kay, 1982). Comfort thus is comprised of a variety of components from the psychological and emotional realms. It exists in the choices of settings women make, and may contribute to the shaping of the picture of childbirth settings in ways that vary among individuals.

The significance of emotional needs that seemed impossible to satisfy in the typical hospital birth situation yet attainable in a homebirth, has been identified among the reasons of women who opted for the latter as the setting for childbirth (Cohen, 1980; Institute of Medicine and National Research Council, 1982; Kitzinger, 1978; Lipkowitz, 1986; Sousa, 1976). Such need was the family desire to be together throughout the process, which practically implied the assistance of partners to laboring women and the possibility of having older children present in the birth or invited shortly afterwards; significant people to the birthing woman being present in the birth without restriction; freedom of movement and

activities, instead of being strapped to a table and legs in stirrups; being in a pleasant and familiar place; and in general anything that makes the labor and delivery a pleasant experience to women, be it the avoidance of bureaucracy, of strangers in the room, of technological equipment, and of uncomfortable exams by strangers. Obviously, fulfillment of all these needs can vary among individuals, with the same issue bringing pleasure and comfort to one but not to another. Yet it is the achievement of the particular aspects of the birth experience that underlies these writings and advocated out-of-hospital births.

In response to the outcry against the discomforts of hospital birth, various settings and services for birth have been developed in recent years, offering a different type of experience (Institute of Medicine and National Research Council, 1982; Lubic, 1976, 1983). For example, hospital birthing rooms are decorated in an attempt to create a "homelike" atmosphere, and in some hospitals, indeed, there are different policies for them than the rest of the labor and delivery unit (for example, no routine prep, women can bring drinks and watch TV during labor). In other hospitals labor rooms became fancy but no real commitment to a change in hospital policies has been made and practiced (DeVries, 1980). Free-standing birthing centers and clinics, affiliated with hospitals, offer a more pleasant physical environment than the hospitals', with minimal intervention in the birth process. Choosing one of these alternatives to traditional hospital birth may stem from the knowledge that up-to-date medical technology exist in case of physical emergency during birth.

Control. Control has also been central to the recent debate of childbirth management and procedures. Having control over the birth means making the decisions as to the nature of the women's physical condition, the situation at hand, and how it should be handled (Katz-Rothman, 1982). Once a woman chooses a service, her power of decision-making is relinquished to outside agents: the attendant and the institution. Attendants have

individual philosophies of childbirth that dictate their way of handling birth. So does every institution. Choosing them implies a choice of a particular way of managing birth, according to their combined philosophies. This is also the case when a choice of a homebirth service is made: it is the midwife who makes the crucial decisions. Historically, when birth was done at home, with the assistance of midwives, it was the latter who decided what to do in each situation. Once women started going out of the home to have their babies, with the assistance of physicians, it was the medical way of managing birth that prevailed (Wertz & Wertz, 1979).

From a feminist perspective, control is a central issue in the analysis of women's actions regarding childbirth. It has been argued that the historical move from the home to the hospital as the place of choice for birth was made by women in an attempt to gain control over their pain yet at the same time they lost control over the situation (Leavitt, 1980). The author argues that in contrast to current views of anaesthesia in childbirth, where women are perceived as relinquishing control over their deliveries to attendants when they opt that at the time, the twilight-sleep movement of the first two decades of the 20th century saw the use of anaesthesia in childbirth as a way to gain control over the birth. Rather than the doctor deciding what type of delivery the woman would have, it would be her decision whether she would be awake or unconscious. Writings about the current situation of women choosing a place for birth which link the issues of control and choice usually aim at rejection of the medical way of birth management and advocate choosing settings outside the system, mostly home birth (e.g. Katz-Rothman, 1982; Longbrake & Longbrake, 1976).

The three issues, safety, emotional quality of the birth experience, and control, are related to one another. Their implications for women's choices of services are clearest when they are dealt with in combination. For example, what stands behind the choice of a

woman who is most interested in achieving the fulfillment of her emotional needs? What does safety, in these conditions, mean to her? Achieving an emotionally satisfying situation, that would also offer safety, may presuppose a degree of control in the situation. It is interesting to see the relationships among these issues as women understand them and their meanings.

Objectives of the Study

The research studied the choice of service for prenatal care and childbirth from several perspectives. The choice itself was of interest, as was the process involved in it. It was examined in the context of individual women's lives, with consideration of the practical factors and psychological processes involved in each individual's choice. While there were obvious issues of interest to me in conducting the research, it was up to the women to dictate the salience of issues in their stories.

Beyond the mere identification of issues involved in the choice, the meanings of these issues for the women were important to reveal. Among these were the meanings of different settings to them, pregnancy and childbirth, attendants and choice. The meanings and possible relationships among the three issues identified in the literature, i.e. safety, comfort and control, were also important to examine. This helped in the determination of their roles in women's decision-making processes.

Finally, the commonalities and differences between experiences of women in first and second pregnancies in making their choices of services were sought. I felt that the information gathered about the choice process and the experience involved in it would be fuller and richer if women who share certain aspects of the experience but differ in others would be included.

Method

Respondents

Demographics. Twenty-six women, 13 in their first pregnancies and 13 in their second, were interviewed. All interviews were conducted during the last 10 weeks of pregnancy, according the estimated birth dates (M first pregnancy = 31.5 days, range: 3 to 70 days; M second pregnancy = 34.8 days, range:14 to 56 days). For those in their second pregnancies, the average time interval between the first and second births was 38.5 months, with the youngest first child being 20 months old and the oldest 5 yrs old at the time of the second birth. Average ages of women in the first pregnancy group was 28.1 yrs (range 25 to 38 yrs) and in the second pregnancy group 32.5 yrs (range - 27 to 37 yrs). The difference between the average ages of the two pregnancy groups is close to the time interval between the first and second babies of those in their second pregnancies, such that those in their first were comparable to those in their second at the time of the latter group's previous birth. All women except two were married at the time of the interview. The two others were living with the fathers of their babies, had been doing so since before the pregnancy, and were planning to continue after the birth.

Table 1 shows the highest level of education completed by women in this study. Most women had at least some undergraduate education, with most having completed a graduate level degree as well. One woman had only completed high school. All women in the second pregnancy group held jobs during their first pregnancies and several did so in their second pregnancies, as well. They were mostly professional, among them a stock broker, three educators, a market researcher, a nurse-midwife, three artists, a social-worker, and two psychologists. One respondent had held a secretarial job before getting pregnant for the first time. In the first pregnancy group, all the women held jobs for at least part of the duration of the pregnancy. They were also largely professional, among them two lawyers, two physicians (one of them an obstetrician), two health-care

practitioners, three artists, a psychologist, a planner, a teacher, and a librarian. Overall, the two groups were comparable in their professional and educational levels.

Table 1. Educational Level of Respondents

	High School	Some College	B.A.	M.A.	Beyond M.A.
First Pregnancy	0	1	5	3	4
Second Pregnancy	1	2	1	7	4

Note. Ph.D. candidates and physicians were included in "Beyond M.A." column.

For several reasons, it was decided to include only middle-class women in the study. Middle-class women are likely to have private health insurance coverage which, combined with their income, may have allowed them to have more choice among services. This greater choice was expected to be reflected in the variety of services that they used. Had low-income women been included, since their choices might have been limited by their lower financial means, such variety would not be possible as part of the study. It was important to include users of a variety of services existing in the New York metropolitan area, to obtain as wide representation of considerations in service choice as possible.

Income of respondents' families was average or above (Median = $45,000). However, at the time of interview the husbands of 3 respondents, who were the main or sole financial supporters of households had been laid off. As a result, these households

had low or no income at the time of interview. It was decided to include these women in the study since they still fit the criteria for inclusion in terms of educational level and general middle-class lifestyle. Moreover, the husbands were professional (one designer and two educators), and their unemployment seemed temporary. The choices of childbirth service made by these particular respondents (out-of-hospital service or homebirth) made their inclusion an important addition to the study, another reason for disregarding their temporary economical situation. These choices of out-of-hospital services were not related to women's economic situation during the pregnancy. The use of these services, as respondents attested, were equally or more costly to them than the use of an attendant affiliated with a hospital.

Sampling criteria. Sampling was done according to criteria that were expected to yield an adequate sample for generating a comprehensive picture of women's experiences in selecting a service for prenatal care and childbirth. Research design stipulations for qualitative analysis (Carney, 1972; Glaser & Strauss, 1967) call for theoretically relevant sampling. The sample in such a research design is not large, yet by careful selection it fully represents the phenomenon in question. By use of qualitative analysis techniques, the sampling can be expected to reveal the nature of the experience sought in the study.

Glaser and Strauss (1967) stress the importance of making comparisons between different facets of the phenomenon. They emphasize the need to highlight the nature of properties of the sought experience by juxtaposing them and pointing to differences and similarities. Since all respondents are involved in the same phenomenon in one way or another, the differences and similarities can yield a rich and comprehensive picture of it. This is also a way to increase the variety of included experiences or facets that constitute the phenomenon. In this research, the decision to include both women in their first and second pregnancy was made specifically in order to obtain as realistic as possible a picture of

pregnant women's experiences. Most of what has been written about pregnancy deals with women or couples expecting their first babies, not with pregnancies that are subsequent to the first (e.g. Breen, 1975; Colman & Colman, 1971; Osofsky & Osofsky, 1972). Yet women's experiences of second pregnancy may differ from the first; on the one hand they may have knowledge from their prior experience, on the other, they also may be aware of the differences between a first-time experience and a subsequent one. It is the duality of the novelty and the repeated experience that is probably inherent in the second pregnancy experience. Sampling was done with the aim of making comparisons possible between women in their first and second pregnancies and thus reflect a range of possible pregnancy experiences.

Another way to enrich the range of pregnancy experience examined was to include women who were having "normal" as well as "high risk" pregnancies. In other words, indications of actual or potential complications in pregnancy and birth did not exclude women as respondents. Previous choice studies tended to include only women with "normal" pregnancies and births (e.g. Cohen, 1982; McClain, 1983; Rosengren, 1961). The rationale used in the present research was that there was no reason to think that women having "complicated" pregnancies and births do not make choices worthy of study. Moreover, the prevalence of complications seems to have increased in recent years, resulting from liberalized definitions of risk by the medical establishment (e.g. Oxorn, 1986; Queenan & Hobbins, 1983). These definitions stem from medical philosophies affecting pregnancy and birth management procedures, and possibly also women's perceptions which influence the choices of service that they make. Exclusion of women defined by caregivers as "high risk" would have led to a small sample, and would yield a narrow range of pregnancy and childbirth experiences.

The service chosen by an individual woman for her prenatal care and birth was an important and theoretically-relevant sampling criterion. It was clear that covering the different birth options available in the metropolitan area was crucial to the richness and ecological validity of the study. Winkel (1983) stresses the importance of this concept to environmental research. The achievement of ecological validity in an investigation is determined by the degree to which the research strategy and its content relate to the characteristics of the situation in the social and physical realms, as well as people's transactions within the setting. Since the aim of this research was to capture the experience of choice of various birth service alternatives in the New York metropolitan area, comprehensive representation of both facilities and users was essential.

Based on this view, it was a necessity for this study to represent the choices of maternity services available in the New York City area and to include women who had selected from a wide selection of services. The nature of their transactions with the services may vary, and thus would enrich the study of the phenomenon in question here. Many combinations of attendant type and gender, coupled with institutional affiliation, exist in the New York metropolitan area. Relying solely on individual differences such as those related to health beliefs and expectations for care and experience in pregnancy was not believed to be sufficient. Rather, it was believed that the variations sought in the research would be found by including people who opted for different combinations of care, and therefore expected to differ in their considerations, priorities and life circumstances. For example, a woman living in a small apartment in Manhattan may be less likely to opt for a homebirth than another who lives in a single family house on Long Island even if their health beliefs concerning childbirth are similar. Women who prefer midwives practicing in hospitals may differ in certain attitudes and beliefs from those who opt for birth with an obstetrician in a hospital. Their beliefs about the nature of childbirth and priorities in their care may differ although they may be similar in their belief in the need for emergency

hospital equipment. Table 2 shows the distribution of attendant type and institutional affiliation among the women in the sample.

Several reasons led to the decision to interview the pregnant women before, as opposed to after giving birth. Interviewing the decision-makers during the process of choice places both the decision and the process leading to it in a real life context, which is missing from much of the decision-making research (Wallsten, 1980). Had data about pregnancy been collected after the birth it would have been masked by the event of the birth itself and the decision-making process would be dwarfed by all that happened afterwards, i.e. the birth, post partum period and adjustment to the new baby (Bennett, 1985; Lumley, 1985).

Table 2. Distribution of Attendant Type and Place for Childbirth of Respondents.

	Midwives		Obstetricians	Total
	MCA	Hospitals	Home	
First Pregnancy	2	2	2	7	13
Second Pregnancy	2	4	0	7	13

The reasons for limiting the time of interview to the last 10 weeks of pregnancy were both practical and ethical. Practically, had I chosen to interview women early in their pregnancies, unless repeated interviews were done later, there would be no way to know whether the early choice of a service was indeed the final one. Also, gathering information

about the process of choice and weighing alternatives might not have taken place. This is especially true in the case of women who would switch services later in pregnancy.

Another practical consideration has to do with amniocentesis, a diagnostic procedure that can be done during the 16th week of pregnancy. Its results are available 4 weeks later, and may be used for abortion decisions. Amniocentesis has become almost a routine procedure in pregnancies of women over 35 and is also becoming common among pregnant women in their early 30s. Many respondents in this research were in their 30s, and a number of them underwent this procedure. Interviewing them before they took the test and received its results, would have been unlikely to provide the information sought in the study.

From an ethical point of view, there was a concern that the interview itself might lead to respondents changing their minds about their services. Though studies and written material about change of service by women during their pregnancies were not available, it was believed that an interview late in the pregnancy would not be as likely as an earlier one to influence respondents in making their choices. It was hoped that the later in the pregnancy the interview was done, the lower the likelihood that such influence would occur. Several weeks after their deliveries most respondents were contacted by phone to find out whether the interview led to reconsideration or actual change of services. No such influence took place.

Sampling

Obtaining the sample. Several methods were used to obtain respondents. Initially a networking technique was utilized, with several sources referring to suitable prospective respondents. Sources were personal acquaintances and several practitioners who provide therapeutic services for pregnant women and who had known me personally. These

included a Manhattan chiropractor, a midwifery practice affiliated with a teaching hospital and a dietician in an obstetric practice affiliated with several community hospitals. Also, respondents themselves made referrals to others. This way the sample was expected to include the desired range of childbirth options regarding both attendant and setting.

When it became evident that networking would not lead to enough women who opted for out-of-hospital services, be it homebirth or birth at the MCA, I contacted these services directly. A note posted at the MCA produced additional respondents from that institution. An independent midwife providing homebirth services was contacted and agreed to refer her clients to me. I left an explanation sheet with her (Appendix A) and she gave it to women who seemed appropriate to her according to the research criteria. Midwifery groups in Manhattan, The Bronx and in New Jersey that provide homebirth services agreed to distribute my explanation sheets among their patients. These efforts did not yield additional women who opted for homebirth and were interested in being interviewed. These and other sampling difficulties I encountered will be discussed shortly.

Contacts with women were established in the following manner. The contact people (the sources mentioned above) asked women who fit the sampling criteria to participate in a study on childbirth, conducted by a person known to her, providing them with information about me. Shortly afterwards I called the women who agreed to participate, to establish initial contact with them, regardless of how far along in the pregnancy they were. In this initial conversation I discussed the study and the interview (predicted length, my preference to do it at their homes, the need for privacy during the interview, and tape recording it). This initial contact was made with most women earlier than the last 10 weeks of the pregnancy, so a later time was set for another phone conversation in which a specific interview date would be set. To confirm and avoid last minute confusions, I called women the night before the interview.

Sampling difficulties. The sampling technique used in this research, and the particular type of respondents sought, were susceptible to sampling hazards, notably those of losing respondents and inability to get suitable ones. When no contact was maintained with respondents during the intermediate months between the time of initial contact and actual interview, a number of things could happen during that period, potentially leading to losing respondents. My study was no exception. First, several people changed their minds and refused to be interviewed when they approached the end of their pregnancies. Secondly, the course of a pregnancy is not always predictable; one prospective respondent lost her baby in the 5th month, another terminated the pregnancy following an amniocentesis; two women went into early labor days before their scheduled interviews; another moved away at the last moment. Faced with these situations, I had to search for other respondents to replace respondents "lost" to the study.

It was particularly difficult to obtain women planning homebirths. They were needed since none of those referred to me by the first homebirth midwife was in her second pregnancy, and because I felt that more variation was needed than to rely only on that single source--a midwife--for women planning homebirth. First, she was located in a suburban area and her clients lived in private homes. This may have been a facilitating factor in their decision to have a homebirth. An attempt was made to obtain women planning homebirth who lived in apartment buildings, with the expectation that the different housing type may affect women's process of decision-making as to whether to have a homebirth or not. This expectation was later confirmed through discussions with several homebirth midwives and an investigator who had done an earlier study of birth alternatives, both of whom confirmed that it is rare when a homebirth is conducted in an apartment building.

I also felt that since most clients of the first midwife were located in that suburban area relatively far from New York City, they used local hospitals for backup services. These are all community hospitals and are not part of the same concentration of institutions used or referred to by other women in the study, all in the boroughs of New York City. However, repeated attempts to get referrals from other midwives delivering at home in Manhattan, Brooklyn, The Bronx and New Jersey were to no avail. They either claimed they had no clients at the time or refused, arguing that they were too busy or wanted to protect their clients' privacy. One midwifery service for homebirth in Manhattan finally agreed to let me post a note on the clinic bulletin board, but not to establish any other contact with the patients myself. They also refused to mention the study to the patients, agreeing only that the receptionist would give out my letters upon patients' entrance to the clinic. Their concern for their clients' privacy was explained by homebirth midwives as stemming out of the nature of the homebirth phenomenon and the people who opted for it. The argument was that for these people it was privacy in their childbirth experience that was crucial, and an intrusion into their lives would be more disturbing than into others'. Reference was also made to the current political situation of homebirth midwives, many of whom abandoned their profession as a result of pressures from the insurance and medical establishments. The less revealed about their professional activities, the better, was the explanation given to me by a childbirth educator who herself had had several homebirths. Lipkowitz (1986) found that women planning homebirths prefer to hide their plans because of others' negative attitudes to the idea and possible pressures to change their plans. In my own contacts with women who had had homebirth in the past, these feelings were confirmed as well.

Data Collection

Description of method. A focused interview (Selltiz, Jahoda, Deutch, & Cook, 1959) was preferred as a data collection method over a structured interview or

questionnaire. The goals of the study and the nature of the data sought, i.e. the revelation of meanings of issues through free discussion, to uncover the ways they related to each other, were the reasons for this decision. Content analysis with a theoretical perspective was planned, to reveal underlying themes in the experiences of women, as well as the relations among these themes. Glaser & Strauss (1967) termed "gounded theory" one that emerges from data, in the absence of an existing one. This indeed was the situation here, i.e. a satisfactory theory was non-existent. To remain faithful to women's realities they have to be allowed to present their experiences from their own points of view. Content analysis was planned, to reveal the emerging themes. The interview thus consisted of a list of issues to be covered, yet their order as well as extent of detail in coverage depended on each woman, as did the addition of other issues deemed relevant to individuals. Respondents indeed raised issues that were central in their own experiences, and questions were asked (or not asked) according to the course of an individual interview.

The topics covered in most of the interviews included a review of each woman's current pregnancy and previous ones of women in second pregnancies, mental images of childbirth and related issues, the process of choice of service for prenatal care and birth, nature and sources of knowledge about pregnancy and childbirth and satisfaction with these sources. Appendix B provides a review of these topics.

The qualitative method of research, including the mode of interviewing and the nature of data analysis was chosen as it seemed most suitable for answering the basic question underlying the study, that of the nature of women's experiences in the choice of maternity services as they appear in the context of women's lives. This method allowed respondents and myself to delve into the intricacies of each individual woman's situation, freed of limitations imposed by a pre-conceived set of questions and the rigid requirements of quantitative analysis techniques (e.g. for sample size and uniformity in the mode of

responses). It thus facilitated the emergence of themes and factors central to each individual and the relationships between these factors and inner processes, activities, and external socio-political forces involved in the actual making of the choice.

The general approach to the investigation was along the lines of feminist methodology, as described by Mies (1982) and Duelli-Klein (1982). Both authors stress the need to study issues central to women's lives and their social position, using a methodology that differs in several aspects from the traditional postulations of social science research. First, there should be equality and mutual sharing of information between investigator and respondents, rather than distance and hierarchical relations in which the former has superiority in knowledge over the other. Indeed, during the interviews I shared my knowledge about the topic as well as information about my own childbirth experience and perspectives on the choice of service with respondents. I contacted the women after their births and discussed their recent birth experiences with them as well as the findings from the study and my interpretations. Second, the study was done while women were pregnant and the issue of choice of service was central in their lives. They were not limited to talking about the specific points that seemed to me related to the choice issue; instead, they were encouraged to lead the discussion in whatever direction they themselves saw relevant. As a result, I discovered the intricacies and the complexity of the choice situation women are placed in in society, and the variety of issues that seem to them as part of the choice process.

The interview session. All interviews except two were conducted in women's homes. The two exceptions were interviews with women who preferred to use a private area in the building where their prenatal service was located. Usually I was alone with the respondent but in a few cases husbands, children or both were somewhere at home at least for part of the interview. They did not intrude and the interview proceeded in relative

privacy. Most interviews were conducted on weekdays, but a few were held on the weekend with women who worked full time. Several others were conducted in evenings, again to accommodate working respondents or those caring for young children.

The interview situation was usually friendly and rapport was established easily. Several women commented positively about the opportunity to be able to talk about the pregnancy with someone other than their friends or family members. The interview was conducted at kitchen tables, in dining rooms or living rooms. All the women offered me at least something to drink. Interviews with women in second pregnancies were usually longer (M=1 hr, 40 minutes; range: 50 minutes to 2 hrs, 35 minutes) than those with women in their first (M=1 hr, 10 minutes; range: 45 minutes to 1 hr, 30 minutes). This difference in length was due to the additional issues covered in interviews with women in second pregnancies, concerning their first pregnancies and their parenthood experiences with their older children. They also tended, on the whole, to provide more details about their feelings and thoughts elicited by the issues we discussed, than did women in their first pregnancies.

Two women were clearly nervous during the interview. Their activities included eating without offering any food to me, and smoking. The interviews were shorter than usual and the women tended to respond with abrupt answers to questions. Given that I had several phone conversations with them prior to the interview, explaining the objectives of the study and the topics that would be covered, there could be several possible explanations for what happened. My explanations might have been insufficient in their cases and they were not as prepared for the interview as others were. They might have agreed half heartedly and felt uncomfortable about cancelling the interviews, although I asked respondents repeatedly during phone conversations whether they were still willing to participate. The content of the interview might have been perceived as threatening or

possibly intruding on their privacy, which could have made several women less comfortable than others in the interview situation. Individual differences in all the above issues may have accounted for the various perceptions and responses to it by respondents.

Data Analysis

All interviews were tape recorded and transcribed. Transcripts were used for content analysis. Themes (e.g. attendant-patient relations, control in maternity care, the image of childbirth) were extracted by use of inferential content analysis (Carney, 1972). Each theme was further analysed to detect its specific components, which were used to describe women's experiences as a whole as well as to find the connections between different issues for each woman. For example, the theme of setting for childbirth included specific issues, among them perceived safety in childbirth, preferences and ways of selecting a service, liberalism/conservatism in labor and delivery management and a woman's knowledge and satisfaction with them. These components were later used to describe ways women understood childbirth services, and also the process of choice individual women went through during their pregnancies.

The inferential approach to content analysis is susceptible to subjective bias (Carney, 1972). It was preferred over others, however, because of the advantage it offers in obtaining in-depth information, which was especially important to the theoretical purpose of the project, in clarifying the experience of choice.

The following chapters present the data and my interpretations of it according to topics that were identified as central in women's experiences. Each topic was related to others, a relationship important to understanding their distinct and combined roles in women's experiences. While the presentation here may seem somewhat repetitious, it remains faithful to women's own point of view.

Choice Of Services

The choices women made of services for prenatal care and childbirth were influenced by two factors. One was their past experience, and specifically whether they were in their first or second pregnancies. The other consisted of their priorities among three issues, safety, comfort and control, that were embedded in perspectives on pregnancy and childbirth and in the services available for choice. Whether or not a woman had experienced a complete cycle of pregnancy and childbirth, as well as her priorities among the three issues, in combination with contextual and individual factors that set boundaries for freedom of choice, determined her choice, the way it was made and her feelings about it.

Women in second pregnancies were in an advantageous position regarding making choices of services compared to women in their first. They had gone through childbirth, which provided them with knowledge of its nature and of their individual way of experiencing it. They were better able to evaluate, in retrospect, their needs and requirements from attendants and from relations with them, and assess available alternatives. In contrast to women in first pregnancies, women in their second knew about childbirth and pregnancy at the time of the interview, and their accounts were more detailed and rooted in what, for them, was realistic information for making the choice. For instance, they were able to base their assessment of attendants not just on the latters' behavior during pregnancy but also during childbirth. Actual delivery became a major component in their evaluation and decisions to remain with or leave previous attendants, and in the processes of evaluating and choosing others. The parenting experience of women in second pregnancies also influenced their focus and priorities in the choice of service. Women tended to focus on their babies more than on themselves, which was reflected, for example, in the emphasis on safety considerations regarding the care of the newborn in the choice of setting. The nature and intensity of past birth experiences also

influenced women's views on childbirth, in general, and their needs from it, also reflected in the choice of services.

Priorities Among Service Components

Only rarely was the choice of service for prenatal care and delivery perceived as a selection of one unit that was made up by two parts, attendants and settings. Rather, women tended to see their choice process as directed either toward an attendant, or less frequently, a setting. The common view, that the choice process was directed toward only one part of the service, usually the attendant, probably reflected the prevalent situation in maternity care delivered by physicians affiliated with hospitals, i.e. women have contact during their pregnancy only with their attendants. For physicians' patients, their entire contact with their setting of childbirth was through their doctors, and they became familiar with it only toward the end of their pregnancies. When the choice began with the hospital, more attention was focussed on it in the choice but the emphasis also shifted in these instances to the physician. Women who opted for midwives affiliated with hospitals began their choice process with the knowledge of the type of attendant they desired, then shifted to the hospital. In contrast to physicians' patients, midwives' patients were acquainted with their hospitals long before the end of their pregnancies. For them, the hospital was an integral part of their choice, more than for physicians' patients, who commented on their indifference regarding the hospital and their lack of choice, in that they had to go to the one with which their physicians were affiliated.

In a few situations it was impossible to separate the attendant from the setting. Those who chose the MCA considered the midwives and also its institutional philosophy and policies. In deciding on homebirth, women obviously started from the setting, home,

but the type of attendant was part of the considerations, as there was no obstetric homebirth service in the New York area.

For women who opted for hospital birth with physicians, the choice of attendant often superseded that of the institution in importance. In such instances, the decision was of an individual physician that they considered, not a practitioner affiliated with a specific hospital. When a hospital birth with midwives was planned, the midwives retained their importance, while the hospital was elevated in importance as well. These respondents were often unable to specify which aspect of their choice was more important to them.

Respondents who planned an out-of-hospital birth had a choice between the MCA and their homes. Those who actually opted for homebirth did not consider the MCA, while those who decided on the MCA had considered homebirth. It is unclear whether this signifies a tendency among choosers of these settings or an artifact of the small sample size.

While the choice of a hospital birth with physicians was often perceived as a choice for prenatal care, opting for midwives, particularly in out-of-hospital settings necessitated detailed considerations of the birth. Indeed, these respondents were more informed about intricate details of the birth process and about their desires for it. They were able to develop a set of priorities regarding the type of birth they wanted that was more individually related to their priorities in life in general, more than those who opted for hospital birth, especially with traditionally oriented physicians.

Changes of Services

A change of service includes two components, leaving one service and selecting another. Choice is the process involving the selection of a new service. Of the 13 respondents in their second pregnancies, 10 provided information about their choices and

changes from both the first and second pregnancies. Of the 13 women in their first pregnancies, 8 provided full details about the services they had been using prior to their pregnancies. Since all respondents discussed the issues involved in choice and change of services, which are the focus in this study, it was less important that the facts about particular services were not available for several women in each group. Overall, the information that is provided and has been examined in the research is based on what women themselves saw as relevant to their choice and change experiences.

Most changes and choices of services occurred at three points in time: before a first pregnancy, between pregnancies, and during a pregnancy, usually at the early stages. Only one woman changed services at the middle, during the 5th month. Among women in both the first and second pregnancy groups, sometimes more than one change and choice occurred during a single pregnancy. Table 3 shows the number of respondents who made changes at different points in time. Table 4 shows the number of changes and choices of services respondents made, in relation to their care during pregnancy and childbirth. Women in second pregnancies made more changes than women in their first, and most of these changes were made between pregnancies. The numbers here are too small to draw definite conclusions, yet the points in time when women tended to make changes i.e., early in the first pregnancy (in both pregnancy groups) and between the two pregnancies, are significant to the understanding of choices and changes of services.

Women in both pregnancy groups were similar in the methods they used to obtain knowledge about services, and the most popular method of gaining credible information was through referral systems. Acquaintances who had been patients of attendants were considered credible sources about these attendants. Opinions of other physicians such as a former gynecologists, pediatricians and general practitioners were also highly valued.

Table 3. Times That Service Changes and Choices Were Made by Pregnancy Group

	Never Changed	Early 1st Pregnancy	Late 1st Pregnancy	Between Pregnancies	Early 2nd Pregnancy
First Pregnancy	2	11	1	0	0
Second Pregnancy	1	8	0	8	3
Total	3	19	1	8	3

Note. Several respondents made more than one change during a pregnancy.

Table 4. Number of Service Choices and Changes by Pregnancy Group

	0	1	2	3
First Pregnancy	2	9	2	0
Second Pregnancy	1	5	4	3
Total	3	14	6	3

Another source of information about services were books (for example, Boston Women's Health Book Collective's "Our Bodies, Ourselves" was mentioned as the initial source for knowledge about the MCA), as well as medical boards or direct contacts established with services.

Reasons and Considerations in Selection and Leaving Services

Women provided information both about their reasons for leaving and selecting services, and about their considerations in doing so. The difference between reasons and considerations was that reasons were directly related to the acts of choosing and leaving services, while considerations concerned additional and less important facts about them. For example, a reason in the choice of midwives over obstetricians in one instance was their explicit policy of staying with women throughout their labor in the hospital. This was the single most important reason for Dianne to change from an obstetrician to a midwifery practice. A consideration in her choice, on the other hand, consisted of other issues involved, such as gender, fee and hospital affiliation, which strengthened her confidence in her decision, but which did not prompt her to select the service. For Nina, who opted for the MCA for her second childbirth, the reason was that it was an adequate compromise between homebirth and a hospital birth with midwives; her considerations in the choice were that attendants at the MCA were female, another was the pleasant physical setting, and a third was the convenient location of the institution.

The distinction between reasons and considerations in the choice was present subtly or directly in women's accounts. Reasons were discussed in regards to the initial aspect of the choice, whether it was the institution or the attendant, and sometimes when the choice process had several stages, there were clear reasons for each one. If there was a change of services, there were also clear reasons for the part of the process that involved deciding to leave a previous service. Ruth, a respondent in her first pregnancy, initially chose a

teaching hospital because several other physicians she was using were affiliated with it. Her other considerations in the choice of that hospital were its location and that "the staff were usually nice." Then she set out to find an obstetrician affiliated with that hospital. She selected one out of the list she obtained, because the wife of one of her other doctors was using that obstetrician, a referral considered credible by Ruth. In the choice of that obstetrician she also considered her being female and her high status on the faculty of the medical school that was perceived as a sign of high professional standing.

Considerations were not always supportive of the choice prompted by one or more direct reasons. Women presented their considerations in favor of, but also against, using a specific service. One instance in which this occurred was with respect to the choice of a place, especially when it was the attendant who was initially selected. Women made comparisons between the setting they were going to deliver in and other places, of the same or of a different type. They then outlined their considerations for and against the use of each place. Overall, the distinction between reasons and considerations was made according to importance of issues to the final choice. The issues that were important were used as reasons, while those that were not, were presented as considerations. For example, when mentioned, gender of attendants was almost always a consideration, but not a reason for choices. Professional orientation or personality types of attendants, on the other hand, were presented as reasons.

There was a difference between women in the two pregnancy groups in the reasons and considerations they used for their change and choice of services. The need to select a service that offered maternity care arose initially for women in their first pregnancy or those planning it. Many had been using gynecological services not offering maternity care or had not been using consistently the same service. As a result, upon getting pregnant for the first time they had to seek a suitable service. Also, women who had specific ideas for their

births, such as Leboyer birth (not available in many hospitals and practiced by only few physicians), those who wanted midwives as birth attendants, and those opting for out-of hospital birth all had to make choices and seek the desired services early in pregnancy, as their previous attendants could not be considered for pregnancy and childbirth. It was the exception for women in first pregnancies to remain with their previous gynecologists. Only two respondents did it, one of them involuntarily, because of a physical condition that led to her rejection by midwives. This may reflect on several phenomena in the context of making choices for services for women. One is the increasing specialization in the field of obstetrics-gynecology, which has been traditionally unified and practiced by the same people. Also, various health services for women that exist in New York offer gynecological services but not obstetrics. Also, women may have had different expectations for their care during pregnancy and childbirth than in their gynecological care.

For women in second pregnancy the most important issue for leaving previous services was related to the attendant's professional conduct during pregnancy and mostly childbirth. Such issues included diagnostic mistakes (of an ectopic pregnancy and of a breech baby), too much or too little medical intervention in labor and birth, rude comments during pregnancy and labor, and failure to appear for labor and birth. Events that happened between their first and second pregnancies (e.g. medical problems, change of living conditions), women's reflections on previous experiences, as well as changes in their perspectives on childbirth and its requirements all contributed to the decisions. These resulted in changes of services that could vary from a change to a different attendant of the same type as previously, or to one that was altogether different. For example, the desire to use the MCA after using a hospital or vice versa, was prompted in both cases by the first birth experience that changed a woman's perspective on the issues involved in childbirth and on her own needs from services.

Previous physicians' elimination of their obstetrics practice was another reason to seek new attendants, and it happened to women in both pregnancy groups. It resulted, in women's opinions, from the increase in malpractice insurance premiums for obstetrics, and was also attributed to physicians' personal life circumstances.

While respondents in first and second pregnancies differed in their reasons for leaving services, their reasons and considerations for choices of both attendants and places were quite similar. In the choice of attendant, personality style or "how the doctor came across" were important, as was his or her professional quality, that was judged, in part, by their hospital affiliation. Location of both the attendant and the affiliated institution were frequent reasons. Gender was mentioned by more than half the women in each pregnancy group as a consideration in their choices, including patients of both midwives and physicians. Preferences were mentioned for both female and male attendants.

Reasons and considerations in the choice of settings concerned similar areas. Slight differences in emphasis depended on whether it was a reason or a consideration in the choice. Three general areas were important in the considerations regarding an institution. The physical setup and structure of a place was important, including its location, size, aesthetics and equipment. Second was the nature of a place, whether it was a hospital or not, a teaching or a community hospital, and its policies and philosophies. Finally, the staff of an institution, whether it included other physicians a respondent was using simultaneously, its level of sophistication, whether it included (or consisted of) obstetricians or midwives, all converged under this grouping. Reasons for choice of hospitals were somewhat different than the considerations mentioned above. Location was a crucial element, as was the general perception of the hospital professional status as a "good" or a "bad" hospital. A reason that was especially salient in the choice of hospitals by midwives' patients were institutional policies. For obstetricians' patients, a similarly

important reason for choice of a hospital was the extent to which it was equipped with sophisticated equipment and facilities for emergency situations. These differences reflect a distinction in priorities between the two groups of respondents, where midwives' patients emphasized safety together with comfort inside a hospital while obstetrical patients focussed almost solely on the medical safety it offered. For those opting for out-of-hospital birth, reasons were usually rooted in the nature of the birth they wanted to have, not in specific characteristics of an attendant or place.

Significance of the Choice

The choice of service was important to everybody, though respondents varied in their reasoning for it, and in the relative significance of different aspects of the choice. Several midwives' patients pointed to their desire to influence a central event in their lives, pregnancy and childbirth. Another frequently mentioned rationale was present in accounts of respondents, midwives' and obstetricians' patients alike, who focussed primarily on attendants in the choice. The long period of prenatal care seemed to them equally or even more important than the childbirth event, and thus they placed high emphasis on having good rapport with their attendants. It was important for them to work with an agreeable practitioner throughout this period. The opposite opinion was also presented, where the compatibility and rapport between the particular attendant and patient was unimportant; what was important was choosing an attendant who was adequately competent and had a reasonable personality, with whom women could get along well on a minimal level. Laura, an internist in her first pregnancy said:

> It is very important to choose someone who I think is very competent and well trained, that's absolutely critical; that it has to be a particular person is not critical, there are many many competent obstetricians in New York, I do not think I found the only one. Also, there are probably several hospitals in the city in which I would have been very comfortable.

Parenthood influenced women's outlook on the making of their choices for services. Kim, in her second pregnancy, presented a view that distinguished between first and second pregnancies in the importance of the choice. She said:

> In a way it is more important this time and in a way it is less important. It is important because I am unlikely to have other children, this is my last birth, so part of me thinks that I want also to have an experience that I can really cherish, which is how I felt with the first pregnancy. So it was worth taking the time and explore options and think about what I really wanted for selfish reasons, for the experience. On the other hand, being a parent and seeing that the childbirth experience is really just a minute compared to the years and years of parenting experiences, it has put it in a lesser perspective.

In their second pregnancies, women saw childbirth in the general perspective of parenthood, and not as an end in itself. While still aware of the issues important in the choice in regard to the birth, it was somewhat less significant for these women.

Attaching importance to the choice does not necessarily result in practicing it. The fact that she did not try to make to make a better choice for herself was a source of tension for Grace, a respondent in her second pregnancy, who recalled the sense of satisfaction she had had with the choice of a hospital clinic for her first birth of twins. Her dissatisfaction with her second choice of a private, expensive doctor was especially painful for her. She said:

> It's hard for me to say it's very important because obviously I have compromised it, but it is. I have anxiety because I have not exercised my choice fully. I am paying for it with anxiety. I am not at ease with it but I am sort of passively letting two things happen, one is I am paying more than what I think I should pay, I am with a high risk doctor and do not have a high risk pregnancy, and the other the

doctor has never asked for my medical records. So it is important to me and I am upset with myself that I have not exercised it fully.

Individual circumstances surrounding the making of service choices influenced perspectives on its importance. Debbie, a woman in second pregnancy who had considered a homebirth and opted for a midwife in a hospital because of safety considerations after a miscarriage, said about the choice of hospital: "For someone who considered having a homebirth the choice of a hospital is really unimportant."

The Sense of Having Choices

Respondents in second pregnancies commented positively about women's having choices and being able to exercise them freely. However, there was also a feeling among them that they themselves had not been able to exercise choice to the extent they would have liked. Sense of limitation or freedom on one's ability to make choices stemmed from various sources. Two sources that were stressed more than others were physical or medical condition of respondents, and financial status. Less important ones were geographical location, which both limited and increased the sense of having freedom of choice, depending on where the woman lived, and professional knowledge relevant to the area of childbirth, which seemed to increase a respondent's sense of freedom to choose.

Limiting factors on women's ability to choose included contextual ones. One such limitation put on women was traced to the insurance crisis, which altered the professional structure in the field of maternity care. There were fewer physicians to choose from, since many were abandoning their obstetrics practices. Ruth, in her first pregnancy, concluded her observations of others' situations:

I feel lucky because I've got a doctor, I know others who have not. . . it's difficult, you don't have a lot of choice. Doctors are not taking any more patients,

> they are overloaded. That's because of the insurance crisis. Most women I know feel if they have a doctor they are lucky and they should go with him.

The insurance industry had a different type of limiting influence according to Susan, in her second pregnancy. She felt one option was favored by the insurance industry over another, and that being able to exercise free choice was a matter of financial ability:

> The financial aspect kept me at the hospital . . . If one has her baby at home and later takes it to the doctor's office for tests and shots (billirubin or PKU) they are not covered in the same way that they are covered in the hospital. In the hospital they are fully covered. At the doctor's office it's considered an office visit, a well baby visit, and while some insurance companies cover that, mine does not.

Physical limitations on choice may seem individually based, but they also were traced, by the women themselves, to structures that have been established by society. These are the limitations on choice that result from individual women's medical or physical conditions and history. Two respondents were categorized as high risk or as having physical conditions that were not permitted to be treated outside a hospital and by anyone but a physician. Karen, a respondent in her first pregnancy who had suffered from a condition of her respiratory system, was turned down by a number of midwifery groups in the city, including those working in hospitals and in close cooperation with physicians, since she was classified as high risk. Midwives are prohibited by law from taking such cases, regardless of how the pregnancy itself progresses. On the other hand, it was their own perception of themselves as "high risk" that prevented five others from considering midwives, even though their conditions were not by themselves limited to physician's care. Among these were women who had had cesarean sections, ectopic pregnancies, and chronic high blood pressure. Perceiving themselves susceptible to risks during pregnancy and childbirth that were not present in other women, all of these women did not see midwifery care as an option that was open to them. Those who felt their options shrinking,

and not everybody did, felt bitterness at their inability to choose midwives because of limitations on their license, that were designed and enforced by the medical and insurance establishments.

Factors that increase a sense of freedom of choice, primarily one's financial status, were not addressed directly in regard to the choice of service. Ann, who recognized that her good financial status provided her with more freedom of choice than other women, said about her pregnancy: "It depends entirely on economic situation, that's a huge part of it. Having help [she has a live-in help] makes such a difference . . . I always know I have an option . . . it gives a lot of freedom."

Having relevant professional knowledge also constituted an advantage that several women had in their ability to make satisfactory choices. Eileen, a woman in her first pregnancy who had done academic research on settings for childbirth, said: "If I got pregnant before doing all this research I would probably have gone straight to the hospital without asking any questions, but knowing what I knew, I wanted it to be a well thought out choice." Respondents who were health-care practitioners also had the advantage of being able to make choices that they felt were more informed than without that knowledge. The 2 physicians may have felt more options were open to them than did lay respondents, yet individual circumstances surrounding the choice-making made it hard for them to exercise it fully. Laura, the internist in her first pregnancy, felt she had not done enough research on which to base her choice on, since at the early stages of pregnancy she attempted to conceal it because of professional pressures, and was thus unable to obtain as much information as she would have liked. Nora, the obstetrician in her first pregnancy, who wanted to give birth at the hospital where she worked, eliminated all male physicians and those who were in her private practice with her, which left only one physician who she felt was "fortunately, both a good professional and a nice person." Thus, as physicians

these respondents may not have had necessarily a better choice situation than did other women because of their individual circumstances.

There were some reflections on a developmental process women underwent, instigated by the need to make service choices. It began early in pregnancy with women's lack of awareness of the issue of choice. Awareness of having choices and a right to use them was important to women upon approaching the decisions concerning their care. They reflected on beginning the process in ignorance, and gaining knowledge and a desire to control their lives as it progressed. They were all midwives' patients in various settings, hospital, the MCA, and the home. Roberta, a respondent in her first pregnancy, said about her feelings when she was considering the midwifery practice, affiliated with a hospital, and after having decided to leave a physician she was unhappy with:

> I felt comfortable with this practice, I was not threatened in any way, but I also knew that if I did not like the situation that after several meetings I could also change. I was glad I had made the decision to change from a situation that bothered me, so when I came here I also felt that if I did not feel good I could change my mind. Many people don't feel that way, they may be in a situation that bothers them but may not realize they can change it. That's how I used to be.

Others' part in the choice.

Only one woman, in her first pregnancy and planning a homebirth, presented her choice as having been made jointly with her husband, a product of their lifestyle and beliefs. Five other respondents reported having changed their initial choice as a result of their partners' opinions in favor or against services. There were both in- and out-of-hospital services among services abandoned and selected. In the majority of cases (20 out of 26), the choice was presented as having been made by the woman herself, without direct influence or joint decision-making with someone else. However, partners and children in

particular, took an indirect part in the decision-making; women tended to consider the needs of those significant others. For example, women in their first pregnancy for whom husband's presence during labor and birth or involvement in prenatal care was important, tended to select services with compatible philosophies, and thus involved the husbands in the process. Another form of considering husband's needs was utilized by Grace, a respondent in her second pregnancy who was an Orthodox Jew. She selected a hospital solely because of its proximity to her home, so that if she had to stay there during the Sabbath her husband could walk with their twins to visit her.

When a service that involved the husband in care and the childbirth event was unsatisfactory in other respects, women did not hesitate to abandon it in favor of another one, that would respond to their other needs. For Sandy, it was important to find a service where her partner would not feel left out, as he did with her obstetrician. The MCA seemed to satisfy the partner's need to be involved, yet when Sandy found out the MCA's emergency arrangements, and that she could not use her own obstetrician for emergency back-up, she decided to switch back to him and leave the MCA. Thus, in this instance the relative importance of other aspects of the service was greater than its policy of involvement of partners. Other respondents did not find a contradiction between their aim of involving the partners and other aspects of services, and it is unclear how much they would be willing to sacrifice had they had to choose between this goal and others.

Considerations regarding their older children played a role in the choices made by respondents in second pregnancies. Women who saw childbirth as a family-centered event, based their choices on service policies regarding siblings' presence or visitation during or after the birth. Location of the prenatal care service and convenience of getting there were important for women who planned to take their young children with them for such visits. Kim reported using such considerations. She rejected a midwifery service

located in a hospital across town from her home and from her daughter's day care center, as she planned on taking her to prenatal visits. In Kim's case, the choice of an in-hospital birth as opposed to an out-of-hospital one, which she had used previously, was also related to her daughter; she felt obliged to do her best to assure the safety of her second birth as a part of her parental obligation to her daughter. While an out-of-hospital birth might have offered a greater degree of comfort, it was seen as less safe, and was thus rejected.

Besides husbands and children, the only way of involvement with others was through information and referrals to services, provided by others. For example, Liz, a patient of a midwifery groups affiliated with a hospital, received a piece of information about these attendants from a friend, which was crucial in her decision to opt for them rather than for physicians. She had been disturbed by stories she had heard about doctors' demeaning attitude toward their women patients and considering pregnancy a sickness. These were unacceptable to her. Midwives' perspective on pregnancy as a healthy condition and their emphasis on establishing rapport with their patients, which she heard about from a friend, motivated her to seek this option for herself. For Susan, friends' stories of complications of mother or baby made her seek a hospital well equipped for emergency situations, although her own first birth was not complicated and she did not expect any problems. Yet her choice of service was strongly affected by friends' input.

Overall, respondents tended to present their choices as their own, though as including significant others' needs as reasons and considerations in the selection of services. Another way of involving others in the choice process was through the use of information provided by friends and acquaintances.

Conclusions

The choice of service for prenatal care and childbirth was a complicated one. It was directed at several components, connected to each other in various ways and perceived differently by different women. While the choice was important, there were women who tended to play down certain aspects of it while elevating others. The relative importance of aspects depended on the user group an individual woman was part of. Midwives' and obstetricians' patients differed in the significance of aspects of the choice.

Influential in the choice were group and individual characteristics of decision makers. Those in their second pregnancies were in somewhat better position than those in their first to make choices, as they were more equipped to assess the alternatives based on their own experience of childbirth. Women's comments on their sense of having choices and freedom to exercise them revealed that contextual structures have penetrated the reality of individuals. Most salient among these were practices of the insurance industry affecting the professional structure and individuals' financial status, as well as the perspectives and definitions of the medical establishment regarding the proper place and ways to care for various conditions.

Having Knowledge and Making Choices

An essential condition for making informed choices, according to the decision-making literature, is that having adequate knowledge about the condition that warrants the choice (i.e. pregnancy and childbirth) and the alternative services available to her. Respondents in their second pregnancies were clearly more knowledgeable than those in their first, regardless of user group, although there was some impact from that also. Generally, midwives' patients were more informed than most physicians' patients.

Knowledge About Pregnancy and Childbirth

Women in their second pregnancy differed from those in their first in that they felt they had first hand knowledge about the complete childbirth cycle. Any knowledge that women in first pregnancy had, was about "generic" conditions of pregnancy and childbirth, not their own. Women in both groups used various sources to obtain knowledge, and differed in the evaluation of what they gathered.

Childbirth preparation classes have been considered a major source of knowledge (though not always a credible one) about the event both in the literature (e.g. Wideman & Singer, 1984; Williams, 1977) and among respondents from all groups. They are usually directed at women approaching the end of their pregnancies, and are taken during the last 10 weeks before the expected date of delivery. This is long past the cutoff point in which services are willing to accept new patients. While several women did indicate they received information that made them introspect on their experiences and desires, the timing of the classes reflect that their actual mission was not to aid in choice. Rather, it was preparation for a generic birth event and designed neither to make women ready to parenthood nor to facilitate the integration of childbirth into their lives, to enable them to construct their preferences, or to help in the choice process. This, as Seiden (1978) sees it, can only come from a sense of mastery that is based on a life long childbirth preparation. While she sees

preparation for childbirth as an educational tool and in a broad sense, in reality classes are limited to instruction about the likely events during the birth, often leaving their participants with the dubious feeling of indeed being "as prepared as could be" yet lacking a basic knowledge of the reality of childbirth, as women in second pregnancy said.

In spite of their criticism of aspects of preparation classes, a number of women in first pregnancies gained strength from taking them. Sandy, a woman in her first pregnancy said:

> The childbirth films that I saw in the class, I felt they were not realistic, there was no pain, quiet, no episiotomies, no complications, no cesarean sections, it was all uneventful; it seemed like a Reader's Digest version of birth- very quick, no gruesome details. It may be better, though, to show the straightforward thing as opposed to the neonatal unit, for an expectant mother.

At another point in her interview she also said:

> The most important source of knowledge were the classes I took with Elizabeth Bing. It was focussed on what I needed to know . . . It was very useful, I was surprised at how ignorant women are, also at my own ignorance. Others in the class were mostly focussed on the pain . . . I think the pain is a given, what I want to know is what I can do to help. It was good knowing what to anticipate and how to alleviate it, not just be there passive.

Liz, in her first pregnancy, summarized the emotional strength she got from taking the classes: "For me that [the class] was the most important source, because I went from being really nervous to saying I can do this". Nora, the obstetrician in her first pregnancy, stressed that not only information about pregnancy and childbirth was given in the classes. She said of her knowledge:

> Obviously, most of the facts [that I know] are from medical school. The emotional things, I picked up from taking care of patients, but also a lot of friends, going

> through it with them . . . I only went to a few classes, and that made me start thinking about ways to deal with labor because before I was really paralyzed. But having read the books and gone to the classes I think I am as prepared as anybody.

"Refresher classes", a short version of childbirth preparation classes directed at people in their second pregnancies, were attended by those who felt the need to gain new or additional information. Others saw it as unnecessary after having gone through childbirth. What determined respondents' attitudes toward the classes, regardless of whether they took them, was the extent to which they had proven helpful in their previous childbirth. The women in second pregnancies were now able to compare information about childbirth to reality, which resulted in their qualified acceptance of the teachings of the classes. Like many others, Debbie found the childbirth film shown in her class to be its most valuable part, yet she was critical of one aspect of it, which annoyed several other respondents as well: "In the childbirth class they don't even say it hurts, and you are so shocked when something happens, like back labor, and it's so painful... Even regular birth hurts, and they only say it's uncomfortable." Susan, also in her second pregnancy, said about her feelings during labor:

> I got most angry at my Lamaze teacher, because I did not feel prepared . . . lying on my back and making a couple of Hi Hi's, that was not enough, it was not a sense of control . . . I don't think that any of that [Lamaze or Bradley] can give the control that one would like to have. I think it's just a process that she has to go through.

The other significant source of knowledge for women in their first pregnancies were books, mostly popular literature about pregnancy and birth. It is rare for women to read about pregnancy and childbirth before getting pregnant, and indeed very few

respondents recalled having developed any interest in it prior to their own pregnancy. Sandy, in her first pregnancy, said about that:

> You sometimes have the knowledge, but the interest is not there, it does not concern you so you do not get anything out of it. It has to come at the right time to get you interested and for you to get the most out of it.

Several women started reading early in their pregnancies, but for the majority reading peaked during the second trimester. It was unusual for those in their first pregnancy to develop an idea about the way they would want to have their own childbirth, that was based on the readings alone.

The essence of the perspective of women in second pregnancy on their experience and its role, is reflected in the following excerpt: "My own childbirth experience is an experience, it is not real knowledge; I can know better because I am experienced." Indeed, women often saw both qualitative and quantitative differences between knowledge from their past experiences and what other sources provided. They demonstrated the superiority of their own experience as a source for knowledge by weighing it against other information sources such as books, childbirth classes, or their attendants. Two women expecting their second babies expressed this view. Said Ann:

> Right now my own experience overrides everything else. Having gone through it and also the books that I have read, like Kitzinger's books, that got filtered through my experience, I'll sort out only the things that were confirmed through my own experience.

Ellen:

> My own experience is the most important source of knowledge for me. It should not necessarily be so because every pregnancy is different, but the only thing that I can really rely on is something that really happened, and the only thing that really happened is not the book or TV or the doctor's opinion, it's something that

> happened to me. It changed my opinion about things, although truthfully I had not had real opinions . . . you know better than him [the physician]; he has the knowledge, you have the experience.

Respondents interviewed in their second pregnancies recalled that in their first, they had sought information and relied heavily on expert sources, such as books and childbirth classes. This was identical to experiences of women who were interviewed in their first pregnancies, who mentioned books and childbirth classes as most credible sources. Similar to past experiences of women currently in their second pregnancies, women interviewed in their first also mentioned relevant experiences of their own and others' experiences as contributing to their knowledge of pregnancy and childbirth. Among these were witnessing or assisting others in labor and birth and hospitalization experiences. Yet, while for women in second pregnancies others' experiences ceased to be influential after going through their own, those in first pregnancies still highly valued these experiences as information sources. In general, this group was divided in the reliance of its members on sources for knowledge. Joanne, a respondent in her first pregnancy said about hers:

> I read a lot, but the best thing I could have done to prepare for childbirth is to witness a birth. I would be more scared if I did not see it . . . I do not expect anything from the class in terms of information, even not for him [husband] although he will see the movies; it's nothing like seeing a real birth. There is a certain detachment that is automatically there when you watch a film. But when you smell the smells and see the skin stretching, your mouth is caught open . . . and the heat from the woman, it's in the air, there is no comparison. It would be nice for him to see the film, but I do not expect it to prepare him for the birth.

While women valued expert-originated knowledge, they also seemed eager to rely on experiential sources. The above account of Nora, the obstetrician, is striking since as someone who serves as a source of knowledge to other women she still needed the additional component of the experience. As she said "Medical textbooks don't teach you about coping with labor" she felt the need for an experiential component to help her. About her pregnancy she commented: "Simply being pregnant, just going through the experience, taught me more than anything else about pregnancy," and on childbirth: "The most powerful thing was being at the delivery of my closest friend. And I realized how difficult labor is, I don't think I really thought about it before in that kind of way." It was thus the experiential component of knowledge that was deemed important to all women. This component was available to women in second pregnancies, since they had experienced both the pregnancy and childbirth. Yet for those in their first pregnancies who had only experienced pregnancy and not childbirth, the difference between experiential and other types of knowledge materialized and they began to develop expectations to get knowledge from experiencing birth.

In a situation that has formal and informal time boundaries to making choices, having relevant knowledge at the right point in time is crucial. Having knowledge from past experience to aid them in their choices, women in second pregnancies were in an advantageous position compared to women in their first. They knew what pregnancy and childbirth were like and were able to discern their reality from outside information. They felt more assured in their ability to develop their own set of priorities based on past experiences than those in first pregnancies. They were less in need of books and preparation classes, two sources of knowledge that materialized too late for the choice of service. The few women in their first pregnancies who were similar in their assurance regarding what they wanted for themselves were those who had had childbirth-related past

experiences. Though not a first-hand experience, this served to assure them more than "expert" sources.

Information About Maternity Services

Women in both pregnancy groups encountered similar difficulties in gathering information about maternity services, to aid them in making a suitable choice. Those difficulties were in part structural, and partly rooted in the nature of patient-attendant relations.

Information about attendants. To obtain information about services, regarding both attendant and childbirth setting, women turned to their attendants. Those planning homebirth had only to get information about their midwives' policies. Physicians' patients differed from midwives' users in the way they obtained the necessary knowledge and in its nature. Former patients were seen by obstetricians' patients as the most credible source of knowledge about a physician. Information gathered from this source was usually limited to personal characteristics (including gender; traditional/liberal; ethnic type; age; tendency to talk; etc) and the name of the affiliated hospital. Rarely was there any discussion of practices beyond general comments about the way the attendant treated patients. No one among midwives' patients obtained information of their services this way. They made up their minds beforehand about the type of experience for childbirth they desired, and obtained information about the provisions of the available services, in order to find the one that brought them closest to fulfilling their needs. Midwives' patients in first pregnancies, whose knowledge of pregnancy and childbirth was lacking because of lack of experience and lack of information originated in outside sources, were able to establish certain criteria for themselves from previous own and others' experiences, about the type of care for pregnancy and childbirth that they wanted.

Services varied in the amount and type of information about themselves that they provided to prospective users. Most midwifery practices make it their policy to inform prospective patients about their policies, the institution they were affiliated with and its policies. The MCA also provides comprehensive information about itself before joining. In private midwifery practices women felt that the initial information they received was indeed satisfactory and credible regarding both prenatal care and childbirth practices. The majority of midwives' patients, including the MCA's, obtained without effort a large amount of information and clear answers to their questions about the care as part of the established policies of services.

Not so with obstetrical practices, which had no established policies of informing prospective patients of their services. Discussions of philosophies of care and of desires for childbirth depended on the women themselves. While the initiation of such discussions is recommended by several popular books about pregnancy, respondents did not find it an easy task to perform, since it put them in a position of questioning or challenging the physician. To Lina, in her first pregnancy, who remained under the care of her gynecologist for maternity care, it seemed unbearable to go and conduct such discussions with physicians. She said:

> From my readings it became clear to me that many women have to make choices . . . they would have to go to clinics and interview doctors, and I was very glad I did not have to do that, because it seemed to me an uncomfortable thing to do. The interview, it's like challenging the doctor. I was happy not to have to face those difficult choices. I would not know what I would ask in such an interview. The questions that are suggested in the books are important but they are not the most significant thing for me; for me, the most important thing is that I walk into a room and feel a level of trust with somebody.

When women did attempt to initiate a discussion of policies at their initial appointment with physicians, the latter seemed usually responsive. However, as the pregnancy progressed, issues that seemed to have been decided upon in the initial meeting surfaced as if they never had been discussed. Susan, in her second pregnancy, said about her initial discussion of drugs during pregnancy and delivery and management procedures:

> When we discussed drugs he honestly gave me his opinion, that he does not believe the birthing process should be of discomfort, that he really believes in epidurals, but he goes with whatever his patient wants him to do and that's something I liked. That's how it was left - that it will be the way I want it to be.

She was in her 7th month when she found out that much of what was promised (regarding positions, movements and use of technology during labor) could not be kept because of hospital regulations of labor and delivery management. At the time of her interview she was preparing herself for the use of drugs because she realized that "natural" ways of pain relief were not going to be available to her. Other women who expressed their desires initially to their physicians also received general assurances. Lina, the woman in her first pregnancy who remained with the same doctor for maternity care, wanted a Leboyer birth:

> When I came to the doctor and asked if I could have it, if my husband could be there, he said: "stop, stop, you have to understand it's your delivery, I'm here to help you and you can have whatever you want as long as it's not medically dangerous." He told me about a pediatrician he delivered who insisted on delivering in bed, and she exhausted herself. [He said:] "that was not the way to do it, but she did not want masks and not this and that." He ended up only with sterile gloves. He said it was a very exhausting labor for her but it was what she wanted and it did not pose medical danger and that's what she got, and "when the time comes we'll talk about what you want." So I thought "great." I am definitely planning to raise it again with him, I definitely want my husband there with me.

> that's really important, but I am not so sure any more that I need everything that Leboyer recommends.

Other women mentioned similar encounters with physicians when they tried to find out the latters' opinion about the use of a birthing stool or bed. The initial response was generally not disapproving, yet as time progressed and relations were established between obstetricians and patients, the doctors clarified their opinions about matters of concern to the patients, who discovered that their previous desires were not important to them any more. Thus, processes of subtle persuasion and influence were probably going on, and by the time they were realized by women it was too late to change services. Women also were less likely to consider changes at such late points in spite of dissatisfaction with the information revealed to them, because of the established relations with their doctors.

Women who did not particularly favor the idea of inquiring about the physician's policies tended to postpone raising issues of concern with them until relatively late in the pregnancy, around the 6th or 7th month. By that time patients trusted their attendants, their relationship had been established in most cases, and it seemed that any position the doctor presented would have been accepted. Patient's assertiveness about her desires early in pregnancy could have confronted her with such resistance to her desires that a change would be inevitable, and not everyone was willing to face that situation. Lisa, a user of the MCA for her two pregnancies, recalled having gone to her gynecologist-obstetrician early in her first pregnancy to outline her desires for the birth and discuss his opinion. She encountered fierce opposition that strengthened her determination to seek the type of experience she desired:

> He got very upset that we wanted this kind of birth [Leboyer], because it might not have fit into his schedule or to the hospital regimen or something like that, and instead of saying he would work it out with us he started saying he is the boss, and started playing like a chauvinist; he is the one who is delivering and he is the boss

> and no one can tell him what anybody wants, and we felt that we yessed him until we left the office.

The difference between the experiences of midwives' and obstetrical patients is striking. The former enjoyed the use of services that attempted to provide information about themselves early on as a policy, thus enabling the making of informed decisions. Obstetricians did not have such policies. It depended on patients to initiate discussions or inquiries about an attendant's policies, obtaining general uncommitted responses or outright rejection of their desires. Sometimes, only later in the pregnancy did women discover that physicians were concealing information about their policies.

Information about settings. As already stated, in midwifery practices prospective users received information about the place for birth early enough to make an informed choice. Again, obstetrical patients faced a different situation, being provided only scanty information and most of it not in time for aid in the choice.

Obstetrical patients' route to the hospital went through their individual attendants. Having to go with their obstetrician's hospital affiliation, a number of them did not see themselves as having anything to do with its choice. Still, Lina's lack of knowledge of her physician's affiliation until the middle of her pregnancy stands out among others':

> He is a successor to my mother's Gyn who was affiliated with [hospital], I knew that he was related there too . . . I asked him if that's where I'll be delivering and he said yes. I did not ask other people about [their hospitals] after I found out that's the place. One reason is because I did not really feel like I had a choice about it. [why?] well, that was his affiliation and that was where we'd have to go.

The information midwifery practices provided about the hospital of affiliation or the MCA concerned both the physical setup, usually including a guided tour of the place, and explanations of the policies and regulations concerning birth. No such information was provided by obstetricians whose patients discovered relatively late in their pregnancies the intricacies of the institutions they were to use for deliveries. The only obstetrical patients who saw their hospitals before the tour close to the end of their pregnancies, were those who went there for tests or other procedures, and they were not interested at the time of this visit in the overall procedures of the labor and delivery units.

Women in first pregnancies were shocked to discover what a hospital unit of labor and delivery looks like. Several said they would have made a different choice had they seen the place earlier. When asked, only 2 (out of 9 hospital patients) were aware that it was possible to visit the hospital unit earlier on, and none had known it before actually going on the hospital tour. Again, obstetricians' patients are in a situation of not having easy access to information, in this case, about their rights as prospective hospital patients.

What aspects of institutions (hospitals and the MCA) were women interested in? They seemed most interested and knowledgeable about the physical aspects of the institution and its reputation. Physical aspects included location, the parking situation in the area, the physical condition of the building (e.g. whether it was under construction) and the crowding situation in the rooms. Hospital size and whether it was a teaching hospital were also issues of interest. Tanya, a woman in her second pregnancy who was a user of a different hospital than in her previous birth, said about what she wanted to know about it:

> We have not visited the hospital yet, we signed up for next week. I do not know anybody who had a baby there so I don't know what door to go into, I need to find that out. [Husband] is coming too. It's important to know that if you come there at 2 in the morning, you want to know where to go.

Practically no one knew anything about policies of the hospital at the time of choice of physician, including those who began their choice process with the hospital. Often women had no discussion of hospital policies with their physicians, nor did they see the need to have one. Lynn, in her second pregnancy, summed up this attitude: "If you have a doctor who will explain things to you before doing things to you at the point when you need the explanation, then that's all that is necessary." This attitude may result from a tendency to avoid knowledge or from being discouraged from raising the discussion and postponing it to later in the pregnancy.

Patients were divided between those concerned about details of policies, and those who were not interested or who only wanted to know if their husbands could be present in all circumstances. One's feelings about her knowledge and the tendency to pursue information seeking seem to account for much of the variations in women's situations concerning their knowledge.

Satisfaction With Amount of Knowledge

Activities aimed at pursuing or avoiding information were already identified as reflecting a basic tendency which, in turn, may have had an impact on the nature of the choices women made. For example, midwives' patients in their first pregnancies were able, in spite of unfavorable structural constraints, to seek the services that would provide them with the childbirth experience they desired. Among obstetrical patients there were several with a tendency to avoid gaining knowledge and others who favored the pursuit of knowledge about services.

Philosophical convictions regarding desirability of having knowledge, a woman's assessment of the amount of knowledge she had, and her satisfaction with that amount were related to each other. Among those holding the belief that pursuing knowledge was

desirable, women who assessed their knowledge as extensive or adequate were satisfied with it while those who felt they had little knowledge were dissatisfied and planned to pursue more. A similar yet reverse situation existed among women who did not favor information seeking: depending on the extent of knowledge women assessed themselves as having, they were satisfied or dissatisfied with it. Midwives patients, on the whole, valued information seeking. Most were satisfied with the amount they had, and those who were not, were planning to pursue additional information. Obstetrical patients were divided among those who valued information seeking and those who did not.

Having a large amount of knowledge was perceived as knowing too much by obstetrical patients who did not value information seeking. Excessive amount of knowledge was invariably perceived to concern complications and as leading to unnecessary worrying. Lynn, in her second pregnancy, said:

> I think sometimes the less you know the better off you are; ignorance is a bliss. A lot of information is not warranted. Sometimes it poses a problem, and it may make someone focus on a piece of information that does not even relate to their health. And it makes them worry, needlessly. That's why during my pregnancy I did not read that many books.

According to this perspective, since one could not control the course of events, there is no use in worrying, and having a large amount of knowledge should be left to the experts. Laura, the internist in her first pregnancy, preferred to pursue knowledge to a minimal degree, feeling she was leaving her physician in charge:

> I read one [popular book], it was reasonably well done. I did not go to the library and get the most recent and best obstetrical textbook. I really do not want to take care of myself, the idea is for the obstetrician to be my physician, I don't want to be my own physician.

This view reflects a belief about the connection between having knowledge, and control over one's care. That woman expected to be in charge of her care if she had more knowledge, something she did not want. This belief was also held by women who did seek additional knowledge, feeling that having knowledge provides them with some control over their situation. While Langer (1983) challenges this belief, women in the present research argued that being educated about issues that necessitate making medical decisions may enable them to avoid unwanted procedures during pregnancy, labor, and birth. Being well read also helped in pursuing additional knowledge and thus being more informed about one's own care, as Ellen, in her second pregnancy, concluded:

> Now when I go to the doctor I know exactly what I want to know, it's more focussed. Instead of a general question I can describe a specific situation when we talk. I can narrow it down, so I gain from it, and I'm happy with it.

The control that some women perceived they have gained through their knowledge could not be easily given up. Susan, in her second pregnancy, said about the extent of her knowledge and its implications on her relations with her physician:

> I know too much to go into a hospital without reservations, and too much to trust unconditionally, so that makes me an informed patient . . . . I would like sometimes someone to lead me. Sometimes I wish I could put total control in the doctors hand, but I still have enough knowledge and awareness that I cant just hand over that whole thing.

Conclusions

Having knowledge about pregnancy and childbirth and about services for care is not sufficient to explain women's choices of services, as is the situation with opinions regarding its pursuit. The two issues probably interact with individuals' perspectives on the conditions of pregnancy and childbirth and on services for choice and their priorities. to

produce an individual's most acceptable one. Overall, women in second pregnancies had first-hand experiences to provide them with credible knowledge about their needs and desires at the time of choice, while those in their first did not, and turned to childbirth classes and books.

Perspectives on Pregnancy and Childbirth

The inquiry into respondents' images of childbirth-related entities revealed the strong relationship they had to the realities and actual experiences of these women, which in turn made questionable the existence of coherent images as such. When asked to discuss an entity (such as pregnancy, labor etc.), respondents in second pregnancies focussed on their own previous childbirth experiences while those in their first discussed others' childbirth experiences or repeated --almost recited-- what they heard in childbirth classes. Their experiences dominated discussions of pregnancy and attendants, since all respondents were nearing the end of their pregnancies at the time of interview and had experienced both. This is similar to findings of spatial images, in which actual experience, especially immediate experience, was strongly evident in indications of the mental structure (e.g. Lynch, 1960; Wofsey, Rierdan & Wapner, 1979). In addition to recounting their experiences, respondents in this research also discussed their views and perspectives on childbirth-related issues. These perspectives and views are discussed in this and the next two sections, as they were embedded in respondents recounts of their experiences, and as these were related to the choice process.

While the connection between image and experience has been evident in the creation of images, as outlined above, the role of the image in influencing activities was evident more in some respects than in others. It had been expected, that the nature of image of pregnancy and childbirth (e.g. as sickness or a healthy condition) would affect the choice of a service. For several respondents the connection was made clear, but for others it was done subtly; the involvement of other factors in the choice may have contributed to the inconsistent influence of the nature of image and the type of service chosen. As a result, women holding similar views on the nature of childbirth sometimes selected somewhat different services. Connection between perspectives and choices was clearly evident in regards to those entities that had to be selected themselves, i.e. between the views and

choices of attendants and settings for childbirth. Yet these choices were also influenced by perspectives on pregnancy and childbirth.

Perspectives on Pregnancy

There was much in common between the images and perspectives on pregnancy of women in first and second pregnancy groups, perhaps because both had experienced it by the time of the interview. Yet some differences did exist, such as the salience of certain issues in accounts of women in their first vs those in their second, or the appearance of some aspects in the accounts of one group but not in the other. Such differences seemed related to individual women's life circumstances in some instances, and to group situations in others. The mere fact of having a young child to care for while pregnant made a significant difference in the views of women in second pregnancies in comparison with their counterparts in first pregnancy as well as their own views during the previous pregnancy. Also, physical discomforts, economic status and career situations were all individually related and resulted in development of unique images and perspectives on pregnancy.

Issues specific to pregnancy groups. Whether a woman was in her first or second pregnancy was profoundly related to some aspects of her views and perspectives on the nature of pregnancy. Most salient as a differentiating factor was the practical matter of having a young child to care for while pregnant. For women in second pregnancies, this was the most important difference between their first and second pregnancies and had practical, physical and psychological impacts on their condition and views.

This was especially true when the interval between births was short such that first children still had to be carried around or were not attending school. Having the other child

implied in such instances additional physical strain and less rest when needed. Depending on an individual's other life circumstances, however, this situation colored the general view of the pregnancy she had. Nina, who had been an art student during her first pregnancy, stayed home during her second, caring for a 20 months old child (at the time of interview). Feeling unable to pursue any of her interests as she had been doing during her first pregnancy, she said:

> For me pregnancy is not sickness, it is not a limiting condition by itself. [In my first pregnancy] I could stand and paint for hours, I was motivated, I had fun and I enjoyed it. Perhaps that's because I felt I was able to do both things at once. One thing did not override the other. This time is different. I feel deprived of doing many things I would like to do. Although I enjoy being home with [child] and doing things for him, I hardly do anything for myself. So the pregnancy is much more difficult. No wonder I complain, and I am tired and feel heavy. Physically it is not very hard and I am not sick, it's just that the other side is missing and that's what's difficult. So I can sit and think about all the other things that bother me. I am not sick or suffering, but I do not do anything with myself. It [pregnancy] is a state that reflects the other things in your life.

Women in their second pregnancies were not focussing on the second pregnancy as a condition in and of itself as they had done in their first. Moreover, they projected this change of attitude to their unborn babies, and also replaced the previous excitement about being pregnant for the first time with a more down-to-earth attitude toward pregnancy as a process leading to having babies. Opinions expressed by women in this group seemed somewhat contradictory in that they expressed both sorrow at the loss of the excitement and focus on the pregnancy that they had had in their previous ones, and a matter-of-factly dismissal of the pregnancy as a condition that warrants excessive attention. Together, these two opinions brought out a practical perspective on pregnancy. Kelley said:

> The first time there was not an hour that went by that I was not consciously aware that I was pregnant, and now hours can go by . . . . If there is no physical reminder I can go hours without thinking about the fact that I am pregnant, it's something at the back of my mind but not as top of the line as in the first time around. And you almost feel guilty about that, because you go: "this poor kid, he is not going to have the fanfare as the first one."

Elsewhere in her interview, she said about pregnancy in general: "I am not one of these women who can say they love being pregnant; to me pregnancy is just getting the baby." From what other women had to say about their second pregnancies a focus on the baby at that time seemed stronger than during the first, when the pregnancy itself had been the center of attention. Thus, on the one hand there was less focus on the pregnancy as a novel and exciting experience; on the other, there was more emphasis on it as a process leading to a result. Grace, the mother of twins who was seen during her first pregnancy by acquaintances and attendants alike as having a "super pregnancy", said:

> I see pregnancy as childbirth. I connect the two. With a subsequent child the pregnancy is less in and of itself. It is simply a means to an end. With the first, I was very much into the pregnancy month by month. Each point in time was an end and each month was an experience. The first month, the sixth month . . . . The second is all part of something that leads to a birth process. The pregnancy is secondary. It's what happens to you when you are going to have another child.

Indeed, the second pregnancy was not a new and unknown condition any more. In several instances women associated the loss of the novelty and their apparent lack of interest in the second pregnancy with the other child's presence. Ann described the difference between her feelings toward the first and second pregnancies, 2.5 years later:

> I keep thinking how it will affect [child], I think about this most of my waking hours. I am not really as positive about this baby, because I feel how it is going to

> affect him. I still think about him as my baby, I am still infatuated with him. Although almost everybody has been through having a sibling, I still think this is going to ruin his little life and how to avoid it.

She said elsewhere in her interview: "It's more difficult emotionally because I felt a lot more special. The first time I felt I was the only person in the world who had done this." Another respondent, Kim, replaced idealism by a realistic view of pregnancy:

> I have two feelings about that. One is like sadness of giving up my innocence, but more than that a sense of satisfaction of being more grounded in reality this time. The first time I refused to look into complications and emergencies. I can see now that in my first pregnancy when reality did not not fit the image that I had I did not change the image, I denied the reality. In this pregnancy I am much more honest about things that are unpleasant, and I feel much less that I have to pretend that it's such a wonderful experience.

The sense of loss of specialty stemmed in part from others' casual attitude toward the second pregnancy, such as husbands' lack of involvement. Said Dianne:

> It's not as exciting being pregnant. My husband is not as excited. In the first pregnancy when the baby kicked for the first time we were both almost in tears, now when it happened he said: "really? isn't it supposed to do that now"?

And Ann lamented: "My husband has been completely out of this one. He was so involved before and now I've gone through the entire pregnancy and he was not involved at all."

Responsibility to her daughter affected not only the way Kim saw the pregnancy but also her way of thinking of the choice of place for birth:

> Now I am more interested and concerned about emergencies, I keep asking the midwives questions about their evaluation of emergencies. Being a mother now

> made me want to look at that much more directly, because it would affect both the parents and baby and also my daughter. I have an obligation to shield and protect her, so if I have to have a section and I need to stay longer at the hospital and have a longer recuperation period it would be very irresponsible for me not to prepare myself. She should not suffer the consequences of my being reluctant to make an emergency plan because it's distasteful to me. Likewise, what would I say to her if the baby died, I feel a sense of responsibility to my daughter who expects me to bring home a baby brother or sister to her, and if I can't I'd better have something to say to her.

Accounts of women in first pregnancies tended to focus on pregnancy as a condition in and of itself. In spite of some references to the baby, accounts were centered around the pregnant woman, her feelings and her life situation. Women sometimes spoke of the spiritual meaning the pregnancy had for them. Karen, in her first pregnancy, said:

> I have found the experience of pregnancy truly miraculous; I did not expect that. I know all the facts, but it feels like a miracle; it's not intellectual, the knowledge that there is another human being inside of me . . . I get teary talking about it.

The pregnancy was on women's minds much of the time, regardless of whether they received "reminders" in the form of physical symptoms. Nora, the obstetrician in her first pregnancy said:

> All the knowledge that I had before was not as important as actually going through the physical thing of being pregnant. I guess I did not realize that you are so aware of being pregnant, all the time. I did not expect that. And especially after the 4th or 5th month.

Roberta, in her first pregnancy, felt it was perfectly fitting to her life situation:

> It's just an amazing experience, I feel this is what I was always meant to do, have a child . . . physically and emotionally. Also I am in that stage in my life. My

> marriage is happy, I am sure about having the baby now. I am really happy with what is happening in my life.

When pregnancies did not occur according to plans for timing or with job situations, they raised negative feelings among women in their first more than among those in their second. Grace, a graduate student and the mother of 18 months old twins, referred to the discovery of her pregnancy: "This pregnancy was not planned, it came upon me. There was a bit of denial going on. I was more into my studies than into this pregnancy." Ruth, in her first pregnancy, who found out she was pregnant unexpectedly, described her feelings as "resentment. I really resented being pregnant". Laura, the internist, who found herself pregnant soon after beginning a new job, saw the pregnancy as a hindrance to her life, regarding her job performance, painting, and physical activities. She attempted to hide the pregnancy, and in general had this to say about being pregnant:

> I was never really very happy about the image of being pregnant. I did not and still do not want to look pregnant. To me it represents in some sense publicly demonstrating what your private life is about, and I find it very difficult. I don't want that at all.

Thus, while for some pregnancy was a welcomed state, in which they felt special, for others it was a time of adjustment to a new life situation. The woman who described her resentment of the pregnancy earlier underwent a period of marital tensions that was resolved only toward the end of the pregnancy. For women in their first pregnancies, adjustments to pregnancy and the approaching parenthood signified major changes in their lives and were sometimes perceived as threatening. Women in their second pregnancies had made big changes in life when they first became parents, and the adjustment to the second pregnancy did not seem as difficult for them. On the other hand, for several women in second pregnancies the impact of having a child on their careers seemed to grow

more negative and irreversible with the coming of their second. Those in their first who commented about the difficulties awaiting them in combining parenthood and career did not see a great problem in continuing their work after their births.

In their perspectives on pregnancy, women in their second reflected on a comparison between their two experiences. The most influential factor on their perspectives was the presence of their first children. It affected the centrality of pregnancy in their lives, and they as pregnant became less important than the outcome of the pregnancy, the baby. Women in first pregnancies tended to focus on themselves as pregnant and less on the baby. Other topics in their accounts were shared also by women in first pregnancies.

Commonalities between pregnancy groups. Women's overall views on pregnancy as a physical condition were interesting. In both pregnancy groups there were women who saw pregnancy as sickness and emphasized the limitations it brought, and others who saw it as a healthy condition and focussed on the high energy and activity level that pregnant women have. To a degree, these views reflected individual women's own experiences. Sandy, in her first pregnancy, suffered from severe nausea and vomiting throughout it. While her previous image, as she attested "had not been a horrible one," when she experienced continuous discomfort her views changed to accommodate the variety of possible conditions:

> My answers would be different now than before I became pregnant. In spite of what I went through, I do not think about it entirely as an ordeal, but there is an element of that. There is this sense of disability and dependency on others. I have felt completely controlled by the pregnancy. It irritates me. The propaganda among pregnant women and in general in our society is that pregnancy is this wonderful state, you look and feel wonderful, you are adored. You are led to believe that all

> pregnancies are like that. I really felt I was a failure in that. I did not feel vibrant, you can't if your head is in the toilet all day.

From the opposite angle, Ann, whose two pregnancies were relatively easy, still admitted to having a view of pregnancy and childbirth that emphasized the limitations it could bring. She said:

> Pregnancy for me has always been the body getting big, people getting nausea, faint . . . . It was very mysterious for me. I am still impressed with two friends who had babies, how much they were able to work and get around the house while pregnant, so somewhere in my head I must have the idea the "you must sit around."

It is unclear how the perspectives about pregnancy have been formed. They seem to have been related to some degree to one's own experience, but obviously this is not sufficient to account for the variation discovered among respondents in this study. Rosengren (1961) suggested social class as an explaining factor. According to him, those who are secure in the middle class have attitudes that emphasize pregnancy as a healthy condition and those who feel less secure and belong to working class see it as sickness. This explanation does not hold here, since women in this study were from the middle class culture. A more satisfactory explanation, and one that probably requires a more systematic study than was done here, is that the origin of a person's views on pregnancy may be in earlier sources of knowledge. Regardless of the nature of their own pregnancy experiences those women who spoke about such early sources of knowledge repeated what they had heard when they were younger as their current views on pregnancy. Since not all respondents discussed early sources of knowledge the evidence is scanty and insufficient to draw conclusions, yet it is important to see whether it holds as an explanation in the face of actual pregnancy experiences.

Another issue that went beyond pregnancy group was the extent to which women reported feeling connected to, or interested in their unborn babies. There were women in first and in second pregnancies among those who expressed a feeling of connection and among those who did not. An examination of these feelings as part of the pregnancy experiences reveals that they were distinct from women's feelings toward their unborn babies. Women who felt their unborn babies were strangers to them still expressed positive feelings toward these babies. For example, Liz, in her first pregnancy, said: "There is something miraculous about it. You can't believe this is really happening . . . I feel so much love for somebody that I don't know yet." Negative feelings about being pregnant also did not necessarily imply that a woman felt negatively about the baby, even if she did not express a feeling of connectedness to it. Rather, women made distinctions between their feelings about being pregnant, their feelings of connectedness to the babies, and the feelings they expected to have toward these babies after the birth. Laura, the internist in her first pregnancy did not find connection between the state of pregnancy and that of parenthood. She said:

> For me, the key issue or one of them is that the notion of pregnancy bears a very little relationship to the notion of having a child. All the bad feelings and symptoms, vomiting and nausea, and gaining weight have nothing to do with having and caring for a child. These are very separate notions. The child is the ultimate outcome but there is very little relationship there in my mind. Although they are obviously related in fact, in a woman's experience of them they are not really related. You just feel ill and incapacitated to a certain extent.

This feeling was probably related in her case to her lack of interest in her childbirth, about which she said:

> The pregnancy and delivery are not the acme of my life. It is something that one has to go through . . . . Essentially the whole issue of pregnancy and

> labor/delivery has been overromanticized. What you really have to worry about is the next 25 years when you have to take care of this kid.

A connection was made between lack of interest in the pregnancy, lack of love or connectedness with the unborn babies, and confidence in the awakening of maternal feelings after the birth. Women in their second pregnancies recalled their anxiety during their first pregnancies and shortly after their first deliveries about not feeling maternal and nurturing toward their babies before and even immediately after the birth. Tanya discussed this experience:

> I am not interested in the pregnancy. I don't enjoy being pregnant, I'm not looking forward to giving birth. That has nothing to do with how much I am going to love this child. Some women get pregnant and feel the best in their lives, they get very maternal and nurturing, I don't feel any of that when I am pregnant. I feel like that when I have the baby, then there is something to love. I don't really love this yet. I am looking forward to it, but I do not have that feeling yet.

Women reported having felt guilt and blamed themselves when overwhelming love for their babies immediately after birth did not take place. Lynn recalled her feelings after her first childbirth:

> I thought at first that I could immediately feel love and affection, great warmth toward this little individual. This person was fine to me, I did not know her from a hole in the wall, I did not have that overwhelming love. I thought there was something wrong with me. I found out over the years that I had to get to know that person in order to love her, it was not something that's immediate. But initially I blamed myself, that was my child, why didn't I feel love toward this child.

Yet in the experiences of these women there was something else that went beyond their individual situations. This was social pressure to feel and act differently than they did. This social pressure was directed at various areas of pregnancy, childbirth and infant care. For example, Tanya spoke about her attempts to breastfeed her baby, her difficulties and

her feelings of failure in her role as a mother. She could not find a source of support for her negative, yet authentic feelings toward the process of breastfeeding and desire to give it up and use commercial formulas. After her cesarean section, she experienced some guilt and pity from others for having missed the "real experience of childbirth", an attitude she grew to resent. The pressure on women, in recent years, to be part of nature, to feel maternal throughout pregnancy, to be interested in it and give themselves to it throughout was lamented about by those respondents whose true feelings differed from it. This pressure can be partly traced to the interest in the phenomenon of "bonding" (Klaus & Kennell, 1976) immediately after childbirth. From the opposite direction, women are pressured toward estrangement from the pregnancy and the baby. This pressure originates in the societal emphasis on the striving toward the "perfect baby", and is evident in the prevalence of undergoing prenatal diagnosis. This pressure originates in physicians and is accepted not as social pressure but as an attempt to benefit from scientific advancements, and thus it may be harder to be recognized as another such pressure. Yet, looking at the two social pressures as representing trends, an interesting picture emerges regarding the tendencies of women who made different choices of services. The women cited above, who found themselves pressured to feel more involved with the pregnancy and the unborn baby, were physicians' patients. Those respondents who lamented about the pressures they encountered in the opposite direction, i.e. to estrange themselves from their babies and undergo prenatal diagnostic techniques against their will, were midwives' patients.

The inherent unclarity of the pregnancy condition as to whether a woman is "one or two" was evident in some of the accounts. At the same time women felt connected and estranged from their babies. This duality of feelings was not necessarily related to positive or negative feelings they had about the pregnancy. Kim, in her second pregnancy, said about her feelings:

> When the baby moves around it's really a little person, it's my child and he [she had amnio and knew the sex] is growing inside me, and this is the special time we are going to have together, a special relationship that nobody will ever have with this child, other people will love it and it will grow up and leave me and love other people, but this is something, if it did not have my uterus to grow in it would not be . . . . It's a wonderful feeling of connection with another human being that you never have after it's born, you get close in a different way, but now we are us. Not like two separate people.

Pregnancy has multiple meanings as a physical condition of health or illness and of a condition involving one or two separate individuals. No opinion should be valued or be justified more than the other in research and in practice. Although the sample size in this research was small and had the potential to be homogeneous in opinions, diverse opinions were expressed by participants. This diversity calls for further research on the meanings of pregnancy for women in our society and to attention to the implications of social pressure on women's experiences of pregnancy and related processes and conditions.

Perspectives on Childbirth

In their accounts of the nature of labor and birth, and in spite of being asked separately about these two phases, respondents did not make explicit distinctions between them. They referred to the childbirth experience as one stage, that starts with mild contractions and discomforts and ends with the birth of a baby. In an attempt to remain faithful to women's views, I have not looked at the two phases separately and this is also the way they are presented here.

Differences between pregnancy groups. As previously mentioned, past childbirth experience served as the most important source of knowledge for women in their second

pregnancies. Those in their first lacked the experience and thus used other experiences of their own and others', as sources for knowledge and construction of their childbirth perspectives. Childbirth preparation classes served as a major source of knowledge that was used to prepare psychologically and practically for birth among women in first pregnancies. Roberta, in her first pregnancy, said: "Four months ago my answers would have been different, because I have learned so much through the childbirth class. It's a major source for my knowledge." And Dorothy said:

> I feel good [about labor] because I took a class, it made a big difference for me because I am not as nervous about it as I had been. Knowing what is going to happen made a big difference for me.

In their second pregnancies women were aware of the differences between expectations and reality. Debbie said:

> The first time it was not that bad but it was not the way we imagined it, there was much more intervention, breaking the waters, internal monitor was used, suctioning the baby. Everything is fine, the kid is OK, but it is still different than what we had imagined. The good thing about it is that now I know it could be different than what we imagine.

Ellen, in her second pregnancy, said about the situation of women approaching their first birth: "In my first birth I did not know much [of labor and birth]; no matter how much you know, it is not enough". Clearly, when expecting their second babies women felt they had an advantage over their counterparts in first pregnancies. This was in line with Lipkowitz's (1986) findings, where women in second and subsequent pregnancies saw their choice for a first birth in a hospital, a result of their not knowing what childbirth was like.

The most salient feature in images of labor, and somewhat of the birth also, was that of pain and the emotions it evoked. Women in first pregnancies expressed more fear of the pain involved in labor than did those in their second. For women in first pregnancies

it was their inability to imagine the pain they were told about that raised their emotions. It was clearly an unknown, and as such a frightening issue, but it was also an unknown that was painful. The following excerpts express views held by several women: "I cannot compare it to anything I know" or "It's a difficult thing to imagine, I cannot imagine so much pain." Women in their second pregnancies recalled that they had known about the pain before their first labors, yet not until they experienced it themselves could they realize its nature and intensity. Sara, a midwife in her second pregnancy said about her feelings before she had had her first baby:

> Before I had my own baby I knew it hurt, I did not think everybody was lying to me. I consider myself very tolerant of pain, and a pretty stoic type, yet I did not expect it to hurt as much as it did.

Women in second pregnancies were obviously aware of the pain involved and fear was expressed in their accounts also, yet their descriptions were qualified by comparisons to their feelings prior to first births. Debbie, in her second pregnancy, said:

> I hope everything will be as good as the last time. I am not really worried this time, I was much more scared last time, because I did not know what I was going into. This time you know, so you know it could not possibly be worse. It could be worse, but I hope it will be similar.

Perhaps resulting from the secrecy surrounding childbirth in general and labor in particular in our culture (Jordan, 1983), women had difficulties sorting the information they got from outside sources about the pain involved in childbirth and in constructing their own images of it. Avoidance of listening to other women's stories was a way women in first pregnancies used to cope with their fear, reasoning that it was not related to themselves. Laura, the internist in her first pregnancy said:

> I avoid listening to other people's stories. I am not sure why. During the pregnancy I had clear reasons for that - if someone had an easy delivery it raised my expectations and if they had a difficult one it sort of frightened me and there is nothing I can do about it anyway. So I did not see any benefit in hearing the spectrum of tales, because they don't apply to you and can only cause anxiety or unjustified expectations.

Lynn, in her second pregnancy recalled how she reacted to others' stories while in her first:

> Most of what I know about childbirth I know from my own experience. Before I had my baby I relied mostly on my mother and cousins. Anything that happens to somebody else did not interest me or relate to me because it was not part of my own family, my own genes. I knew their experiences would be totally different than mine . . . [Yet while mother's and cousins' experiences] did not refer to me. I had a totally different experience than they all did.

A concern about their reactions to pain and their behavior during labor was rather salient in accounts of women in first pregnancies, yet were largely absent from those of women in their second. These concerns were expressed as fears of "losing control over oneself," "being in a state of total panic," or simply "losing it." The two respondents in their second pregnancies who were concerned about it were women who had had cesarean sections, for whom going through labor was equally an unknown as it was for women in first pregnancies. Tanya, one of these women, said:

> If I have a natural delivery I would like it to be as pleasant as possible. I don't want to see myself screaming awfully and gripping the sides of the bed; you see movies on childbirth where women are in control, doing the breathing, and they really seem to go through it nicely, they handle the pain well. I would like to be like that, with a lot of dignity, I don't want to lose it emotionally. I hope that I have some control and that it's not a horrible experience.

In contrast, Susan described her image, based on recollections of herself during labor: "I see closing the eyes and quinching your face but I see it with tears of joy, I don't see it as something to be feared." Women in their second pregnancy who previously had vaginal deliveries took for granted that during intense pain, each woman reacts as she feels, regardless of whether it is "nice" or "dignified" according to everyday behavior criteria or not.

Women in first pregnancies relied to a large extent on childbirth classes to provide them with knowledge of techniques to relieve pain. They recounted, almost recited, what they were told in the classes about ways to relieve physical discomfort, when to leave for the hospital or the MCA. Regardless of whether the class was focussed on one of the major techniques (Lamaze or Bradley) or whether it was an eclectic class, the instruction was believed to be of major help in relieving pain. There were other women in this group who did not adhere to the class instructions and relied on it mainly for knowledge about the stages of labor and institutional management procedures. They were not sure how to deal with the pain and generally saw it as a matter to be handled by medical interventions. While these distinctions may reflect differences in focus among childbirth classes, they also seem to reflect individual perspectives on the possibility of control of labor pains. It was also evident in comparison with observations made by women in second pregnancies. A number of women in first pregnancies believed that labor pains could be controlled by the use of the right technique. Glenda, a nurse in her first pregnancy, said: "My interpretation is that there is going to be pain, it's pressure on the uterus which can get so intense that you interpret it as pain, but if you keep thinking it will go away." While acknowledging that a variety of factors account for an individual woman's labor experience, Nora, the obstetrician, attributed much of the ability to handle pain well to taking childbirth classes. She said:

> Those patients of mine who have been going to classes and are serious about preparing themselves do a lot better, so obviously it's painful but there is a whole spectrum of what people can do, and some people have easier labors than others, also some have different pain tolerance than others, all kinds of combinations of that, but I really think that basically being prepared, that's a large part of it, and the people who do best are the ones best prepared for it. After doing some readings and going to classes myself I feel much calmer now, and hopefully I will get through it OK.

Recalling their own labor experiences, and regardless of the intensity of their past labor, women in second pregnancies concluded that breathing techniques were not sufficient to control labor pains. Instead, several suggested that one has to let the body go through the labor process, focussing on relaxation and thinking of the nearing end. Kim found the breathing techniques helpful not in controlling pain but in distracting her mind during labor. She recalled:

> The sense of being so out of control, which at the beginning of labor was so frightening to me, I had felt it was happening to me . . . . Once I surrendered myself to it it became very exciting . . . . This is something my body knew how to do, all I had to do was let it do it. I found the breathing exercises very helpful [to] distract my thinking mind so my body can get on with its own work. I sensed that my body knew what to do and how to do it, and all I had to do was let it happen. All I had to do was not get in its way.

Susan expressed it as

> A roller coaster...it just keeps going, and you can't yell to the person to stop it, it's going to keep going until it's over. Sometimes there is a slow decline but mostly it's a fast, uncontrollable experience that you are trying to get through.

Indeed, the attitude to the classes among women in second pregnancies was mixed, on the one hand appreciation of the information they provide about the process of childbirth, yet on the other questioning their value and focus on control of pain.

Respondents who were dissatisfied with their past childbirth experiences attempted to make changes in their plans or activities so the birth itself would improve, as well. This could be done in various ways. Taking a different type of childbirth class and changing one's behavior and attitude from passivity and embarrassment to ask questions to assertiveness about her concerns was one woman's way to achieve it. A change in service was more common. This varied between choosing an attendant who held a philosophy of childbirth management that was similar to a woman's regarding liberal administration of painkillers, to the choice of the MCA with the hope of having a totally natural birth, devoid of interventions. Women in second pregnancy were determined to have it better this time, whatever the meaning of "better" was for each of them.

An issue that was crucial for women in first pregnancies, and on which several of them based their choices of institution, was the role of the husband during childbirth. His presence at the birth, under any circumstances, was seen as having utmost importance, for emotional support and encouragement. Lina, in her first pregnancy, said: "I definitely want him there with me, that's really important". Roberta, also in first pregnancy, said: "I would not be able to go through it without my husband, he gives me a lot of strength." While others also could not see themselves go through the experience alone, they were concerned about the husband's ability to provide support in a situation that was as novel to him as to his wife. Karen, in first pregnancy, said:

> I see my husband there for the experience, I do not expect him to be of much help. I do not expect him to support me in the way that I am going to need support. I see my husband's role there as making it absolutely as easy on me as possible. He sees

> primarily the baby and not me, and I think that during the birth those needs are going to conflict, and I only want him to worry about my comfort and let me worry about the baby. And I do not think this is going to be able to happen.

Indeed, in reports of women in second pregnancies, husbands did not appear to have provided the emotional support women expected from them. Rather, they sometimes appeared as a hindrance and at other times as peripheral in a scene where the woman herself was central. Susan admitted:

> The surprise of the labor was the anger I felt toward my husband, partly because of what happened when we left the house, he acted as if he was going to work in the morning, taking a shower . . . instead of talking to me. It was his way of dealing with stress, but it was not what I needed. [At the hospital] the anger just grew, he wanted me to do things that I was supposed to be doing, breathing and relaxing, and although I needed someone with authority, I did not need someone to voice over me.

It seems that women, and couples, had high expectations about the involvement of both partners in the birth. In their second pregnancies women lowered these expectations, anticipating support from professional attendants rather than husbands.

Finally, there was a tendency among women in their first pregnancies to focus more on themselves and their activities during labor, compared to women in their second. The latter group was more focussed on the baby and on issues of parenting, expressing their views in the following ways: "For me, a good birth experience is one that ends with a healthy baby" or "the birth experience seems minute to me, compared to the years and years of caring for the child."

The actual birth was described very similarly by all women, regardless of their pregnancy and choice of service, as a highly emotional time, a miraculous event. The

baby's coming out signalled physical and emotional relief, the end of the hard work preceding it: "It's a long day, but at night you get a terrific present." Women in second pregnancies tended to be articulate about their feelings and thinking at the time of birth. Kim recalled:

> There was a moment when her head poped out and her body was still inside me, it was the most curious sensation, a moment snatched out of time, she was not quite born yet because her body was still inside me, but she was not really belonging to me anymore because her head was out and she was breathing in. It really felt miraculous as if not in this sphere. Not part of real time and the real world.

Differences between patients of obstetricians and midwives. There was a tendency among obstetrical patients to see labor and childbirth as dangerously unpredictable and inevitably resulting in complications of some sort. They were thus concerned about safety issues and about making advance preparations for emergency situations. Whether they absorbed this view before or during their pregnancies is unclear, as is its source. The issue appeared subtly and often was addressed indirectly, as part of descriptions of settings or attendants and needs from them. Ellen described her decision to opt for a doctor rather than a midwife for her second pregnancy by saying: "I went through too many things to believe that childbirth can be safe." Susan described her choice of a hospital:

> Since my first birth I've learned about other people's pregnancy experiences, and about complications, for example a baby not breathing. I wanted a hospital where my pediatrician can be, where they have emergency equipment to deal with any problem.

However, several other obstetrical patients held negative opinions about the "over medicalization of childbirth" in America, so that a generalization to all obstetrical patients would not be appropriate.

Midwives' patients seemed clear in acknowledging the existence of complications in childbirth and also the low frequency of such developments, and tended to focus on other types of experiences. Comments like: "Pregnancy is a healthy condition though it is different from my normal state" or "childbirth is not a sickness, I am not sick, why should I go to a hospital?" were frequent. Again, these views were not limited to midwives' patients. Overall, while those who opted for midwifery care tended to see in pregnancy and childbirth healthy conditions, those who opted for obstetricians were divided into a group that was highly concerned about complications and another that was similar in its views to midwives' patients.

Cesarean Sections

Cesarean sections (CS) were mentioned frequently by respondents, regardless of the pregnancy or the user group to which they belonged. It may be related to the high rate of this procedure in many New York area hospitals and to its increasing use in replacing other ways of handling complications of labor and delivery (Shorter, 1982). This is partly the reason why I decided to devote some discussion to it, in addition to its occurrence in the first birth of 2 respondents and its being mentioned by others. In other words, it was not just its occurrence but also its entry into the consciousness of women as a possible childbirth experience, that contributed to its significance.

Perspectives of women who had experienced CSs. The two respondents who had had CSs were similar in their views and feelings regarding this procedure and the prospects of having it again. In spite of the difficult recovery, they felt their childbirth experiences were not unpleasant and that there were advantages to it over vaginal birth. Tanya said:

> Once you have had a cesarean in a certain way it was easier, the recovery was harder but the birth itself was quite pleasant . . . if it's a cesarean [again] I'm not going to be upset because I know it's not a horrendous thing.

Kelley commented:

> [in a CS] you are more in control, it's very calm, even the pain is controllable whereas with labor and birth I always think you have no control over the situation, you say irrational things, and that part is sort of unnerving to me. In a section you can control the pain if you don't move but in labor you can't.

Both experienced respondents hoped to have a vaginal birth the second time for reasons that had to do more with life circumstances and external needs (e.g. appearance, fast return to usual life style) than with unfulfilled psychological needs. Kelley put it as follows: "The only motive I really have now for having a vaginal delivery is not so much because I want to experience childbirth but I want to be normal again faster." Tanya said: "They say I have a 50-50 chance [of having a vaginal] . . . I hope I do, because with a baby at home I do not feel I have the luxury of being in bed for two weeks." Yet it was clear that both respondents did not feel strongly about having a vaginal delivery. They played down the emotional significance of childbirth, saying they were most interested in what was safe for themselves and their babies, and did not care about the birth itself.

Kelley:

> I am not one of these women who really need to experience childbirth; the birthing process was very unimportant to me. I only wanted what was safe for me and the baby. I think the birthing process is something that is overrated. I wanted the baby but I did not care how she got here.

Tanya:

> I carried this child for nine months just like everybody else, I did not feel I missed out on a thing. The only thing is that it's harder, you have had a major abdominal surgery; recovery is slow and hard . . . . I do not think that having a regular delivery as opposed to a cesarean, that one is better than the other. The most

important thing about childbirth is that it goes well. It's out of my hands almost. I only have a little bit of control.

These women did not see themselves in the position of having any control over what happens to them. They put safety, as defined by their physicians, as their first priority, and resigned themselves, almost with relief, to the prospect of having another cesarean. Kelley: "Even though I did not go through labor I realized I really prefer not to."

Both women were very different from the type of cesarean mothers pictured in the birth reform literature (Cohen & Estner, 1983). They are depicted as carrying emotional pain and sometimes guilt, seeking to make up for the lost experience of childbirth; they are also described as having negative feelings towards themselves (e.g. guilt) and their attendants. In contrast, Tanya and Kelley were not particularly interested in the childbirth experience and did not actively seek vaginal birth after cesarean (VBAC). The small size of the sample here is not enough to provide an alternative theory to the experience of cesarean and planning for a second birth. Yet it does provide an additional perspective on CS and its impact on women's views and planning of future births, to the body of knowledge we now have.

Perspectives of other respondents. Very few respondents (2 out of 26) saw positive aspects in CSs. Most respondents (24) sought to avoid it or ignored the possibility of its happening to them. There was a difference in perspective between patients of midwives and of physicians.

While expressing fears and desire to avoid CS, it was two physicians' patients who pointed to positive aspects to this procedure, being spared of painful labor and the possible

benefit a cesarean could be to a baby in distress. Both women preferred having a planned CS than go through labor and then have the operation. Dorothy, a respondent in her first pregnancy, said:

> The worst thing would be going into labor and then having a cesarean section. I know of women who had cesareans and then felt cheated. Right now I do not have these feelings. I understand it's a harder recovery but the advantage is you don't have to go through labor, so I would not be horrified if I was told beforehand that I have to have it. There is nothing I can do, there is no way to predict it, I just have to learn about it and be prepared for what happens.

Laura, the internist in her first pregnancy, was thinking about the possible benefit of having a cesarean to the baby: "My feeling basically is that it is worth doing twenty cesareans if you prevent damage to one newborn."

While expressing negative feelings about cesarean sections and their implications, midwives' patients also spoke about choices available to women, indicating that a cesarean may be one of several options, one which is better avoided. Lisa, in her second pregnancy, who chose the MCA, said:

> We were not opposed to cesareans, but we were interested in not having to push the issue if you did not need to, just because it is available. It's unnecessary medical care . . . that's pain and suffering, it's an expense that is expensive, which may or may not be necessary.

Debbie, a patient of a midwife in a hospital recalled her older sister's experience of delivering a breech baby after hearing doctors talk about a CS. She said:

> It affected me, how committed she was to not having a section. I saw that you really don't have to have a section right away at the hint of trouble. That made me look more into choices and not rush into having a section.

Midwives' patients were confident about having choices regarding having CSs since they made a distinction between situations where one was necessary and others when it was a matter of choice. They wanted and attempted to minimize the chances of having a CS because of their negative view of it. All respondents saw birth attendants as having decision-making power as to whether a CS is called for. Yet while physicians' considerations were either questioned or received unconditional trust, midwives' patients knew their attendants would use CS as a last resort. Joanne, who was planning a homebirth, said about the difference between a physician's and a midwife's practices:

> I do not want to go to the hospital with a doctor who wants to be out in two hours, does a section, whatever, with a heavy duty insurance malpractice; I know that [the midwife] will be patient and we will go through a longer labor than any doctor would. She is not in a haste. And when it's time for the birth the birth has to be the priority, not the golf, dinner or the show.

Susan, a physician's patient in her second pregnancy, described her feelings during labor:

> There is fear in labor, but to me that is fear of "Oh my God, when will they tell me I have to have a C section." It all comes back to the lack of trust in hospitals and doctors. When my doctor came in and said "We can either be here for 1 hour or 5 hours and it all depends on you", I said to myself "I'd better listen to her because she controls the decision of a C section," although I felt like yelling at her. [I thought] if I did not take the nurses' demerol, they may tell me my labor is too intense and I have to have a C section. That's where a lot of my fear comes from, it was not fear from the pain or of going to die.

This excerpt from the account of Roberta, a midwife's patient in her first pregnancy was in complete contrast:

> When I think of birth I think of having this kid naturally, I don't know how I would deal with a cesarean, and if I have to have it, having been treated by the midwives I know that would be a last resort, when it would really be needed.

The attendant and his or her labor management practices were important factors for these women in determination whether a cesarean is to be done. For midwives' patients, the choice of attendant and place for birth were ways to influence their chances of being recommended for a cesarean. This was one way to control one's birth experience through the choice of a service, that was utilized by women who felt strongly enough that they ran the risk of having a CS more with one type of attendant and service, physician in a hospital, than another. On the other hand, other women may not have perceived having a CS as a risk that they were taking with a certain service more than with another. Rather, having a CS was perceived by them as a given, determined objectively by attendants, and not something that they could influence.

Conclusions

The difference between women in first and second pregnancy groups was bigger than differences between user groups. Women in second pregnancy were more focussed on the baby in their perspectives of pregnancy than women in their first, who saw themselves as central. In their views of labor and childbirth, women in first pregnancy differed from those in their second in the extent of their fear.

Perspectives on childbirth provide the main link with the choice issue. Women in their first pregnancies did not have clear ideas about the nature of childbirth, which resulted for some of them in the absence of clear preferences regarding the service for choice and the nature of the childbirth experience. CS was another possible link between the images of pregnancy and childbirth, and service choice. Midwives' patients were more ready than were physicians' to attempt an influence on the nature of their births to avoid CS, by making a choice of services that claim commitment to its avoidance.

Only few respondents referred to childbirth as a state of sickness or health, which could help connecting it to preparations for the event through choice of service. Midwives' patients and several obstetricians' patients indeed saw it as a healthy state, and complications as only one of various possible developments of the birth process. Reference to childbirth as a dangerous event, necessitating medical care, was not evident directly but could be inferred from accounts of the preparations necessary for dealings with complications that seemed imminent.

Perspectives on Attendants and on Relations with Them

The type of service for which women opted was often personified in the attendant they had been in contact with during pregnancy. For long periods those under physicians' care did not encounter their hospitals at all and focussed only on their doctors as their service for maternity care. Experiences dominated respondents' images of attendants, the rest being basically views or perspectives on them, as reflected in the following discussion. Clear connections can be seen between views on attendants and respondents' choices among them.

Patients' Perspectives on Attendants

Difference between pregnancy groups. Their past pregnancy and childbirth experiences played a central role in the choice process of women in their second pregnancies, regarding the decision to leave or remain with previous attendants, and in selecting new ones. They had some advantage over women in first pregnancy, in that their experiences clarified their priorities for them. These focussed on issues of personality style as well as professional judgement.

Changes of attendants were made in various directions. Among previous patients of physicians there were changes to other physicians or to midwives. Previous midwives' patients changed to other midwives but no changes to physicians' took place between the first and second pregnancies. One respondent did change during her first pregnancy from the MCA, where the care is given by midwives, to a private obstetrician, but her change was related to institutional policies of the MCA rather than the type of attendant. It is questionable whether the lack of changes from midwife's to physician's care between pregnancies is due to the small number of respondents in the study or indeed it signifies a phenomenon, where women who have experienced midwifery care tend not to turn to physicians afterwards.

Unfulfilled expectations from attendants in terms of activities and attitude during labor was a crucial factor in decisions to leave and in priorities to seek new attendants. Less central yet present were considerations related to the rest of prenatal care. Dianne, a respondent in her second pregnancy, realized that most important for her was the attendant's presence during labor, based on her first birth experience, involving slowing down her labor (to await her doctor's arrival), then augmenting it (to reactivate the now almost non-existent labor process) by hospital nurses. After learning about midwives' philosophy and practices, she decided to switch to their care. She also came to believe that a woman would be more understanding of the experience of labor, thus first she turned to a female physician, whom she left after the suspicion of her carrying twins was proven wrong, then changed again to the midwives' care. Susan, who had had a negative labor experience with a female doctor, who yelled and scolded her for "not performing sufficiently well" said:

> I was disappointed at my doctor, I expected her to be there, I expected more help from her. She appeared and told me when to push, she really intimidated me into pushing by saying: "We could be here for 5 more hours or we could be here for 1 more hour and the choice is up to you." I did not like this, because I needed to know I was doing the best I could . . . and the pushing has not started yet so there was no reason to criticize me yet about anything. I think there should have been more concern on the doctor's part.

This experience left her resolved to change both her attendant and her own attitude and activities so her future relationship with him or her would be different from before also. During her second pregnancy she sought a person who could provide emotional support, and during her pregnancy became more informed and assertive herself.

Disagreement with physicians' professional judgment was another factor that lead to leaving and searching for new physicians. Again, women referred primarily to the birth itself as their basis for drawing conclusions. Specific procedures were a basis for evaluation on the professional quality of care provided. Tanya had had an unplanned CS due to her baby's breech position, diagnosed by an ultrasound during labor. Her physician's seemingly careless judgement with regard to her prenatal care made her resolved to find the opposite type for her next pregnancy:

> I wanted someone stricter, I felt like I was neglected the first time, we could have had a real disaster there. I felt ignored. I had been going to him for 10 years, he is very nice. He did not mean to be negligent but he was. He had become a fertility specialist and his focus has changed, I gained too much and the baby was late and he never did a sonogram, which would have told him she was a breech. This one is a real stickler about weight, I am thrilled . . . . He cares a great deal about weight, I needed this kind of discipline. I wanted someone older, more traditional, perhaps a father figure.

It was the avoidance of procedures and tests that Tanya attributed to lack of concern on the physician's part. She became determined to seek another physician, who would be the opposite type of person and would provide better care. This interpretation of the lack of interventions as neglect in care was expressed by women in first pregnancy as well, and seems to refer more to a specific user group than to past pregnancy experience. Overall, however, first pregnancy and childbirth experiences made women aware of their needs from physicians. When these were not met, they knew what they were looking to avoid as well as what to find, even when this was a general tendency such as "a good doctor", "a nice person" etc in the physician, that was difficult to define and distinguish from other traits.

Those who decided to remain with their old attendants, also based their decision primarily on their care during childbirth. Like their counterparts who switched attendants, they also underwent a process of refining their priorities and criteria for an attendant, examining their attendants and deciding they were adequate to fulfill their needs. Ann said about her physician:

> I was impressed that he came on his day off to deliver my baby. He was concerned about the baby. There were a lot of difficulties in communication the first time that made me feel negatively about him. There was a lot of information during the first pregnancy that he did not give me, what to expect [from the fibroids] also I had such difficulties afterwards. I continued going to him because I felt that if I looked at it objectively I could ride over [sic] these difficulties, that the most important thing was the baby's health, and that he was really a good doctor, and we have had some personality problems, almost everybody I know had some kind of personality problems with her doctor, but the baby was most important.

Previous patients of midwives also had needs for changes, yet they chose to remain with the same type of attendant. Kim, who had previously used the MCA yet had a hospital delivery because of premature labor, decided that the MCA's policies were too rigid and thus unsatisfactory to her. Still preferring midwives' care over physicians', she set out to look for a private midwifery practice affiliated with a hospital.

The search for a new attendant could also be influenced by a positive experience during the first pregnancy. Women who were satisfied with their first births were looking to match previous services that they were unable to return to. Nina, who had used a private practice of a female physician with midwives that had closed down at the time of her second pregnancy, said about the midwives she met at the MCA:

> You cannot compare with [previous midwives], nothing can compare with them, in terms of pleasantness, the personalities, the approach. So we said to ourselves that although this is the MCA, the people here are not as special as those at [ ], and we were disappointed at the beginning. They are midwives but they are different. It was disappointing.

Unlike those in their second pregnancies, women in their first were guided in their search and choices by priorities that were determined by other experiences or causes, some of which were health-related, or "images" they had about health practitioners. Their priorities were based on notions of health and on the nature and needs of a generic pregnancy and childbirth, not their own. Combined with their past experience, such factors influenced the choice process of women in second pregnancies as well, yet they were secondary to childbirth experiences. The following section examines salient issues in women's perspectives on attendants, which affected their choices and their later reflections on it. Clear distinctions in perspectives emerged according to patient groups.

Comparison between patient groups' perspectives. Respondents who opted for obstetricians had two issues to guide them in their choice: professional skills that seemed superior to those who also considered using midwives, and personality type, which determined to a large extent the relations between doctors and patients. Those who opted for midwives were primarily interested in their philosophy as an alternative to mainstream obstetrical care.

Women's views on childbirth, and to a lesser degree of themselves and their health, were central in their perspectives on attendants and as such influenced their choices. Regardless of whether they had considered using midwives, women who opted for obstetricians' care were concerned about the unpredictability of labor and saw the

possibility of unforeseen complications to be high. In such a situation, they reasoned, they were safer under the care of a physician who they assumed would be better equipped to diagnose and handle the problem. They perceived safety in childbirth as equal to medical care. Ellen, in her second pregnancy, said:

> [how do you see midwives?] I simply went through too many things for me to believe that birth can be safe. Two of my friends went to midwives, they both ended up with sections, so why take the chance? Midwives are less safe medically, if you look at the whole process with midwives they always have to have a doctor in attendance, so if there is a doctor why do it all . . . it's all a matter of luck. You don't know, and I am not willing to take the risk, to start calling an ambulance.

Kelley said:

> It's too risky for me . . . I am aware that they are trained, but to me, why take the risk, if anything goes wrong . . . I can't see the advantage of using one because regular obstetricians do the same thing plus they can handle emergency cases.

Laura, the internist in her first pregnancy, discussed midwifery practice, comparing it to physicians':

> I have not felt favorably toward the practice of using nurse practitioners as birth attendants rather than obstetricians . . . [I feel] strongly that there are many potential complications of pregnancy and of labor and delivery and you want to have the facilities available to handle them, and you want to have the people available who are going to be able to recognize them. I think it's unnecessary and unfortunate when people sustain these complications or when fetuses are subjected to them without the appropriate care because they have chosen for psychological or folkloristic reasons to have less than optimal care . . . . [re complications] Midwives are less well-trained to recognize them and cannot themselves intervene quickly . . . . Midwives are more likely to hesitate to intervene actively with what is called "unnatural procedures", and in this day and age that's unwarranted.

Professional skills of obstetricians were not questioned by their patients. Neither were they questioned by midwives' patients. However, other issues related to the professional skills in the use of physicians for childbirth were raised by Sara, herself a midwife in her second pregnancy:

> People don't understand you can pay for the fanciest Park Avenue doctor but that doctor is not there . . . . People say to us "if there is a problem you are not equipped as a midwife." I'm not equipped to handle the problem but the truth is, you go to your fancy doctor, you go to the hospital, and if the doctor is not there to recognize the problem you are depending on a nurse who may or may not be a good nurse, that you have never met before, or a resident if it's a teaching hospital, that may be a first year resident. The nurses have to recognize the problem and call the doctor to come in.

Questions regarding the medical judgement and considerations of physicians in deciding on procedures were raised by obstetrical patients and midwives' patients alike, who were suspicious about motives other than the patient's needs in deciding on interventions such as cesarean sections, medical augmentation of labor, and tests during pregnancy and childbirth. The malpractice insurance crisis was the most salient factor. Physicians' decisions and recommendations were seen as sometimes based on a concern of being protected in case of a lawsuit, or just to fulfill the requirements of insurance policies. Among patients of obstetricians there were both respondents who voiced concerns as well as others who were indifferent to physicians' basing treatment decisions on insurance-related considerations. The latter did not mind taking tests even though neither they nor their physicians believed in the necessity of these tests. They accepted doctors' insurance-related concerns as legitimate. Lynn, who had to change obstetricians because her previous, more experienced physician ended his obstetrical practice, said about her new,

younger and less experienced physician, who sent her for four sonograms during her first pregnancy:

> He was young and a little bit insecure. He was not certain, so he wanted to play it safe and decided to give me sonograms, to make sure about the size and the date . . . . He probably wanted to play it doubly safe so he made me take more sonograms.

Others, however, were upset that they had to take a sonogram, a procedure they thought hazardous, because of insurance considerations of their physicians. The potential for establishment of healthy work relations was not high in these conditions. Grace commented bitterly about her doctor, who sent her for an ultrasound to clarify a two-week difference between the date calculated on the basis of her periods and the one estimated on the basis of a physical examination: "[she wanted me to take it] just for insurance purposes. . . . Not because of clinical judgment but because of insurance if she ever gets in court with me." As cited earlier, Joanne, a midwife's patient, said:

> The doctor wants to be out in two hours. He does a section, whatever . . . . . Heavy duty malpractice insurance, I know that [the midwife] will be patient and . . . when its time for the birth the birth has to be the priority, not the golf, the dinner, or the show.

For obstetricians' patients, several of whom expressed it directly and others who subtly hinted at it, midwives' limited use of diagnostic tests was a sign of lack of concern for patient's condition. Dorothy, a respondent in her first pregnancy, recalled how she felt when having to choose between a midwives' and an obstetricians' practices. Upon finding out that the midwives did not want to begin prenatal care before the 12th week of pregnancy, she opted for the obstetrical group, commenting:

> I wanted to see someone now, I was feeling so bad . . . . I also knew there were tests that they could do immediately and did not quite understand why the midwives did not want you to come until you were three months.

In contrast, midwives' patients were looking to avoid excessive interventions, especially when not ultimately essential. Liz, a patient in a midwifery group affiliated with a hospital, in her first pregnancy, was attracted to midwives partly because of their approach to the use of tests and procedures: "[I decided to go to see the midwives] when I heard from a friend that midwives are simpler, they do not do a lot of things to you unless you need them, so if you don't need the reassurance of medicine." Roberta, who considered using an obstetrician, decided to use a midwifery group:

> I did not have another one [sonogram; first one was taken with previous attendant, an obstetrician], probably because I went to the midwives because they don't do it routinely. Doctors' patients go through so many tests that seem to be routine, sonograms, glucose, alphefeta, on the fourth month, if the baby had a disease what would I do about it anyway at that point. Things I don't think are necessary. It costs a lot, unless maybe if there was an indication . . . . Some people probably feel more comfortable taking all these tests.

Aware of the variety of normal appearances in labor and delivery, midwives hesitated to intervene medically, a tendency that was crucial for their patients. They compared this to obstetricians' approach of readiness and willingness to intervene. Prenatal care given by midwives did not include routinely doing as many tests as under obstetricians' care, notably regarding ultrasound. Overall, however, it was the avoidance of the increasing number of procedures and interventions in prenatal care and during childbirth that was a source of satisfaction for midwifery patients.

Midwives' practical experience of assisting in childbirth was highly valued by their patients. "Doctors know about medicine, but midwives know about birth" was Debbie's way to express this view. Midwives' ability to diagnose existing or potential complications in pregnancy and birth was not questioned by their patients. Sara, the midwife commented: "We are so experienced in the normal, that abnormal things stand out to us . . . . They [physicians] are so oriented to the abnormal and the sick and doing surgery, they don't know what normal is like." Midwives' affiliation with physicians and hospitals was a sign of good professional standing to their patients. Women made a distinction between lay- and nurse-midwives in favor of the latter; lay midwives were not seen favorably as practitioners by most midwives' users in this study. Yet since none of their patients was included in the study (they declined to be interviewed), their evaluation of their attendants' professional standing cannot be compared to that of non-patients.

Physicians' general tendency to intervene medically by the use of technology or drugs during labor and delivery was mentioned by respondents from all user groups. Among obstetricians' patients two trends were noticeable, opposing and welcoming of such interventionist tendency. Those who mentioned this tendency with concern did not feel that during labor, when they anticipated not being in decision making capacity, that they could trust their attendants to refrain from interventions. A few of them attempted to prevent that from happening by accumulating data on conditions, such as prolonged pregnancy, that could result in the employment of unwanted procedures such as labor induction. They provided the physician with data in advance and attempted to convince him or her of non-interventionist approaches to such conditions. The other group of obstetricians' patients, who welcomed physicians' tendency to intervene saw it much like doing tests was seen, as a sign of concern and good patient care. Even when skeptical about the necessity of certain procedures, they tended not to question the doctor. Ann, in her second pregnancy, said about her experience: "I question whether I had to have an

episiotomy [as the baby was premature and very small]; [but] my doctor is very cautious for the baby which makes me very happy." Others expressed satisfaction with physicians' belief concerning pain relief in labor:

> My previous doctor did not care, he was not the one giving birth . . . . This doctor believes there is no reason in letting women suffer with contractions every 4-5 minutes for three days, which only increase if you don't give them Pitocin, because after all it's a natural hormone. Although it increases the pain it rushes the birth.

Women from both user groups who criticized physicians' tendency to intervene saw it as stemming from the latter's overall professional philosophy. In addition to doctors' philosophical convictions that led them to intervene, the possibility that their commitment to intervention actually reflected lack of professional confidence was also mentioned critically by respondents. Grace recalled that during her first birth of twins the obstetrician panicked and resorted to emergency removal of the second baby without waiting to check the monitors on how he was doing:

> [these are] Medical interventionists who don't look before and see if this is a healthy pregnancy . . . . They just wanted the interventions because I had twins . . . . They even have their whole medical assurances around them to tell them these are healthy babies. They were not necessary but you have them there to tell you. It was kind of no trust in anything. In order to be sure you intervene in a natural procedure. They don't even trust their stupid monitors.

She commented about having to undergo a sonogram in her second pregnancy for a week's difference between her own dates and the doctor's conclusions, based on physical examination: "A top-notch doctor should have confidence; she should know what a pregnant woman should feel like. I asked myself why the doctor did not have confidence in her own clinical judgment."

Relationship With Attendants

Similar to their expectations for personality types and professional competence in attendants, women also expected to develop relations of certain nature with them. Women in second pregnancies based these expectations on their first birth experiences, but similarly to those in their first, on other experiences as well, on changes that they underwent during the period between their pregnancies, and on what they absorbed from other sources.

Respondents can be divided into two groups, expecting to establish "traditional" or "non-traditional" attendant-patient relations. The first group included only obstetricians' patients, who accepted the traditional, submissive patient role. In the second there were both obstetricians' and midwives' patients who defied submissiveness and tried to be actively involved in their care.

Traditional expectations focussed on either the personal or the professional aspect of relations with physicians. To those who focussed on the personal side of relations, achieving a personality match, or "feeling good" with their physicians, was of utmost significance. Unable to specify what was important to them in an attendant and in their relations with him or her, these women limited their responses to general comments about the nature of "good" relations. Ellen discussed her satisfaction about finding the obstetrician for her second pregnancy:

> Until you enter the [doctor's office] feeling at home, being comfortable with everything and in asking about things . . . . You imagine that you want a good doctor but you cannot put your finger exactly on what it means, until you get to that doctor and you say: "I could not ask for anything better than this."

And Lina, in her first pregnancy, said about the same issue:

> You have to be very sure of the relationship you've got with your obstetrician, the primary care person, because it's such an intimate relationship, not just because it

> involves intimate parts of your body, but because they are sharing this very exciting and personal life experience of yours. You really want somebody you feel comfortable with, who will enjoy it with you and will communicate it to you.

To these women spending time during prenatal care visits talking with their physicians about issues other than their care, was a source of pride in the good relations they had with them. They were aware of, but willing to ignore, physicians' tendency to talk about external issues rather than provide information about their care. Ann said about her obstetrician:

> In general he would say - "what do you want to know." He would not volunteer information. He'll sit with me for as long as I want and would talk with me about anything. We talk all the time. About diet, my feelings, my husband. He'll give me the time but basically when you walk into his office he'll say: "what do you want to know."

Seeing themselves in no position to judge on matters of professional competence, all the women in this group assumed that their physicians were "good". Ann was proud about having developed friendly relations with her doctor throughout her years of being his patient. She was aware of not getting information about her condition, which included (as she later found out) cysts on her ovaries, fibroids that developed during her pregnancies, and an ectopic pregnancy followed by an operation that was done almost too late. Yet she still summed up her opinion about her doctor: "After all, he is concerned, he is a good doctor, that's why I stayed with him." Lynn, holding similar expectations, was vehemently against providing patients with information about their condition, reasoning that it would result in misunderstanding and unnecessary worries. She said about her doctor and her relations with him:

> He is young and we've got more like friendly relations, so when I got pregnant I said to him: "you've matured, it's four-and-a-half years later, you've had more experience . . . I hope you won't make the same mistakes now." They were not big, his mistakes; he was just too quick to tell me things about my condition, it was not necessary, it put worries into my head.

For the other women with traditional expectations for relations, the personal side of their relations was unimportant compared to the focus they placed on the doctor's competence. They reasoned that the physician was competent and busy, and saw no need for friendly or warm personal relations beyond the professional realm. The two physicians who were in their first pregnancies belonged to this group. Laura, the internist, said:

> I was not looking for someone to adopt me as their daughter. I looked for professional evaluation among other physicians that I knew. I found things about her practice that I liked, like that her rate of cesarean was low, that she was relatively conservative. I was not looking specifically for a woman, though I was certainly pleased to have one . . . . What was important to me was someone who was competent, who was well trained, who seemed to be a reasonable person, someone who was straightforward and easy to talk to . . . I think relations with patients are not very important.

Kelley, who had a cesarean section previously and opted to remain with the same physicians' practice, said about them and her relations with them:

> Between the older doctor leaving and the new doctor joining, I also grew to appreciate my own doctor, at least we have some rapport. I was not unhappy, I know about others who fell in love with their doctors, it did not happen to me, but I think they are good, competent, I like the hospital, their location is good, they are right across the street, so it was a combination of these factors . . . I have a fairly positive image of obstetricians even though my doctors were older and patronizing

> and defensive. I asked afterwards for an explanation why I had the cesarean, I was not second guessing his opinion, I just wanted to know . . . they are cautious but overall I feel that doctors who go into that profession are probably more caring.

The misgivings in the personal side of their relations with doctors were not seen as causes for concern to these women and were referred to as unimportant. While several of these respondents specifically played down their importance in the choice of attendant, others indicated that they would have preferred the situation to be different, but that they had adjusted to reality. Kelley expressed this view: "I would prefer to have a doctor I liked more, but this is OK too, he is a good doctor." The opinion that one could have been just as happy with other physicians was voiced by these women. This was the opposite of the previous group of traditionally-oriented respondents, for whom the particular match between doctor and patients was not replaceable.

To women with traditional expectations from attendants, whether their focus was on personality traits or on professional competence, it was clear, as a part of the patient role that they adopted, that the physician held all control over their care. They did not think of challenging obstetricians' judgment and decisions. Instead of control they spoke about the trust they had in their attendants, even when that went against all that they knew of pregnancy management. Lina, who was concerned about taking skin medications, turned to her physician for answers. She recounted:

> I asked him about the medication I was taking for my face. He is also the director of a clinic for prostitutes, and many of them are also drug addicts, and he said to me: "you will be surprised how much you can abuse yourself and still deliver a healthy baby. 1 or 2 or 3 would not hurt the baby." That relieved me. I know him, I trust him.

Tanya, in her second pregnancy, recalled an encounter with her doctor in regard to taking amniocentesis:

> Now with the new doctor, I trust and like him a lot, so I said to myself, let's see what he'll say [about taking the amniocentesis] and he said "absolutely." I never even had to raise it. I was ambivalent, it's an invasive procedure, it's not something you feel good about, but he did not even discuss it with me.

It was the physician's taking authority that was attractive to these women. This is how they had expected their relations with their physicians to develop, and with their expectations met, they were satisfied. Indeed, there was high satisfaction among the group of women with traditional expectations. Professionally they did not feel there was any room for them to criticize or question their physicians. When the personal approach of their physicians was not satisfactory, they tended to play down its importance. When it was successful, they had even more reasons to be satisfied.

Respondents who held non-traditional expectations for relations with attendants included midwives' as well as obstetricians' patients. The non-traditional expectations were for information sharing by attendants about matters of care and treatment recommendations, being given choices about care, and exerting influence on it. They expected their attendants to know them, develop expectations for them and provide care that was individualized, not routine, and suitable to their physical and psychological needs. Sandy, a physician's patient in her first pregnancy, outlined her expectations:

> The choice of a doctor was very important to us, because we wanted control over what the birth would be like. We had a set of needs and went around to see where we could have them met . . . [obstetricians] have to be gentle and soft, it's different than with any other medical assisters, I think it's a different kind of medicine, they have to be different, compassionate, maybe that's because I believe that women who are pregnant are not really themselves, I've seen the change in my own character, they need a different kind of assistance.

Karen, whose decision to remain with a physician was involuntary, following her rejection by several midwifery practices because of a physical condition she had, said:

> Her style is of full disclosure. I feel she had told me absolutely everything about anything in the process. She writes down all the medical terms so I can pursue it if I want more information. I see her as running the show, with my permission, giving reassurance, if things do not proceed normally, telling me the options and her opinion of these options, and letting me make a fully aware decision. She will not make the final decision.

Eileen, a first pregnancy respondent who opted for the MCA, had very similar expectations:

> [how do you see the attendant?] I see that person taking things under control. I have a fear of not being able to handle, with the pain, I see the care provider as someone who will be able to lead me and my husband. We have never been there, so it will be sort of a guide, someone who will have answers to questions no matter how stupid, not just saying "Don't worry, I'll take care of you." It's important to me to be in control and know that if I do lose it someone will help me get back on track. I wanted someone with a lot of experience, someone for reassurance and guidance but not leading the show, letting us make decisions.

While women with traditional expectations were largely satisfied, those with non-traditional expectations were in a different situation. There was satisfaction at the fulfillment of non-traditional needs if these were also shared by the attendant. Apparently, several of the obstetricians of non-traditional women did share their views, providing them with information, encouraging their information-seeking, taking the information they provided as credible, and giving them choices among possible treatments. This resulted in women's satisfaction with their choices. In other instances, however, there was no such match between patient and attendant's expectations from the relationship, and patients were

largely dissatisfied. Grace, the previous user of a hospital clinic had been disappointed that a physician unknown to her had attended her first delivery. She said about her relations with her current doctor: "I am disappointed, I don't need a chummy relationship but I would like to have a working relationship. This is the one thing I am sorry about, not having looked for a doctor who is more into his patients."

Midwives' patients who were satisfied with their care felt that their expectations were largely fulfilled. They spoke extensively about information sharing, and compared their encounters with midwives to those they previously had with physicians. Liz, in her first pregnancy and a patient of a midwifery group affiliated with a hospital, said:

> The midwives have been a very good source of information. Sometimes they volunteered to encourage me to ask questions, I am not a big question asker. And when I did have questions we sat there for as long as it took and they explained everything.

Roberta, also in first pregnancy and a patient in the same hospital-affiliated midwifery practice said:

> The first time I had 20 minutes worth of questions, and I know if I had an hour and a half worth of questions the midwives would have sat with me there. Whereas with the doctor I felt I was in a factory, there were many women there when he spoke to me. He said: "don't listen to anybody, I'll tell you what to do, take these vitamins." It was 3 minutes total. I felt like I was rushed and like I was just another patient. With the midwives, they offered information also.

Sara, the midwife in second pregnancy had this to say about physicians' practice regarding information offering:

> Physicians, even the good ones, don't have the time. Their focus is on other things, on the high risk person, on gynecological surgery. They are busy. Most women are intimidated by doctors, and they go in and they have questions that

might be silly, but they see the doctor walking out "Any questions?" with his hand on the door. They just don't have the opportunity to develop a real relationship. Midwives try to give you the time. They try to stress education. They try to stress the emotional component of what's going on in the pregnancy.

Several women in this group wanted to have control over their care, which for midwives' patients was partly the reason for their attendant choice. Depending on an individual woman's interpretations of control, several felt they were given some of it. Liz, the patient in a private midwifery practice, enjoyed being given some choice in her prenatal care, such as deciding whether to come for weekly or biweekly prenatal visits during the last four weeks of her pregnancy. For Eileen, a patient of the MCA, doing her own urine test in each prenatal visit meant having control, as were the free access she had to her medical chart and to all the building. For Eleanor, another MCA patient, it was being consulted about procedures, that she saw as control. The satisfaction these respondents had about the compatibility between their aspirations for control and reality is in line with findings about perceived control among other patient groups (Langer, 1983). However, the difference between perceived and real control is reflected in the difference between the above patients' reactions and those of others, also MCA patients, who found out that when they differed from their attendants in opinions regarding critical aspects of care, the latters' opinions prevailed.

Among women with non-traditional expectations for relations with attendants there were those who trusted their attendants' professional judgment unconditionally, much like those with traditional expectations, and others who qualified their trust. They included both midwives' and several obstetricians' patients. Midwives' patients were among those who trusted their attendants completely, as the account of Liz reveals: "I trust them. . . the reason I went with them is because I wanted someone that I could trust so whatever they

say I accept." Is there any difference between the trust midwives' patients and obstetrical patients with traditional expectations placed in their attendants? It seems that the sources for trust were different. Among traditional patients, trust originated from lack of interest in the ways attendants were making decisions regarding their care. They did not consider not trusting their attendants' professional judgement, which was accepted by them as necessarily correct. Not so with women who had non-traditional expectations. They put trust in their attendants out of knowing the philosophy of care and the background for making decisions. Moreover, they saw themselves as participants in such decisions and accepted that beyond a certain point the attendant has more knowledge than themselves. Thus, while both groups trusted their attendants unconditionally, they differed in the sources for their trust.

Those who qualified their trust in attendants were all obstetrical patients with non-traditional expectations. They suspected that physicians had motives other than the needs and welfare of their patients in making treatment decisions, and they believed in patients' right and need to obtain information pertaining to their care. Their expectations were not met in their care by their obstetricians. Not participating in decisions, not feeling that their attendants saw the importance of getting to know their patients as individuals, they did not feel that the decisions made by their physicians were necessarily trustworthy.

Conclusions

Women's priorities regarding their care were clearly related to the type of attendant they opted for, to the type of person it was and also to the nature of their relations with him or her. Obstetricians' patients who saw childbirth as dangerous sought attendants who they perceived as able to provide them with assurances regarding emergencies. Several of them were also interested in developing rapport with doctors. These were the women who assumed the traditional patient role. Those who were similar to midwives' patients in

views on childbirth also were similar in the nature of relations that they sought with attendants. Although respondents in this last group, among them both midwives' and obstetricians' patients, were interested in having high standards of safety in their care, for some of them issues of control over their care were evident also. Those who opted for obstetricians who did not share their views found themselves in an incompatible situation with their attendants, and were dissatisfied with aspects of their choice. Those who had either traditional or non-traditional expectations that were shared by their attendants were in compatible situations and were satisfied with their choices.

Settings For Childbirth

Perspectives on settings for childbirth varied both according to pregnancy and user groups. Previous childbirth experiences influenced the way women in second pregnancies thought of settings and their choice. First, the ease of a woman's past birth experience affected her views of the necessities for childbirth, such that an easy first delivery raised women's confidence about their ability to undergo another with no need for sophisticated equipment around them, and vice versa. Second, a respondent's experience with a place of birth influenced her subsequent desires, either to match or to improve her future experience, based on a comparison with the first. Also, respondents' evaluations of settings according to their priorities among safety, comfort and control were strongly related to their user group. For example, women who opted for hospital birth with midwives were convinced that they could achieve comfort and freedom without compromising safety, all inside hospitals, while those who opted for physician's care were aware, yet dismissed the importance, of comfort and control. They were willing to sacrifice them for the sake of safety.

The Hospital

Since the 1930s going to the hospital to give birth has been the common thing to do in our culture (Wertz & Wertz, 1979). This may be the reason why all women referred to it somewhere in their accounts, regardless of the type of place for which they themselves had opted. The hospital served as a point for comparison for women in describing the place they chose and their considerations.

All respondents except one saw the hospital as offering safety in cases of complications. However, there was disagreement regarding safety and necessity of hospital provisions for an uncomplicated birth. The one voice against safety of the hospital in any situation belonged to Joanne, who opted for a homebirth:

> I feel most safe at home. [why?] because there is not all these unnecessary medical interventions, with a doctor who wants to be out in two hours, who does a section. If I gave birth in a hospital and anything happened to the baby it would be harder for me to forgive myself; if I gave birth at home and something happened to the baby I would mourn but would not regret.

She felt it was safer for her to be away from the hospital for birth, believing that merely being at the hospital can turn a "normal" birth into a "complicated" one. This opinion is similar to those recorded by Lipkowitz (1986), who interviewed women who had had homebirths.

All other respondents were in favor of going to the hospital if an emergency arose. There were more variations among women regarding hospital use in uncomplicated childbirth situations. Both groups of women planning a hospital birth, midwives' and obstetricians' patients, included respondents who were in favor of, and in opposition to, out-of-hospital birth if no complications were present or expected.

The two hospital user groups differed in their opinions about various issues in hospital care and stay, more than they differed in their views of safety. The following are excerpts from two interviews, one with a midwife's patient, the other with an obstetrician's, each referring to the safety issue, weighed against comfort and control. Kim, in her second pregnancy and a patient of a midwifery group affiliated with a community hospital, said:

> The nicest thing would be to give birth at home. It is the most comfortable place, and you can have whatever relatives or friends you want there, and you don't have to deal with bureaucracy at all; I just think the stakes in the gamble are too high . . . . The best place to find is a hospital where they make it as much at home as possible, so if you want to drink herbal tea or lie in bed you can, just like if you

> were home. But if the baby is born and it is not breathing you are right there where all the best of the 20th century is available . . . . I feel that if you were home and something went wrong that could have been averted, that would be terrible. The parent would then always carry the feeling of somehow being responsible for the tragedy, and it is hard enough on the parent without having a burden like that.

For Kim it was important to give birth in an environment where attention was given to parents' feelings, where comfort has been considered, and where patients had a degree of freedom regarding their activities during the birth. Yet medical safety was not necessarily sacrificed; rather, all three aspects of care seemed to her possible to obtain inside a hospital. Laura, the internist in first pregnancy had a different view of hospitals:

> I do not think [the hospital] is the most pleasant or comfortable environment, I would never say that. However, I think it is the safest environment. That overrides, absolutely, the comfort issues. . . [at the hospital] you relinquish certain elements of control, both in terms of where you are, who is going to attend you . . . privacy, all these issues, they are real, you do relinquish some of those features, but life isn't perfect, and it is absolutely worth it . . . the safety issue is of prime importance.

Although aware of the other issues in hospital care and stay, Laura clearly saw medical safety as overriding and was willing to compromise all other aspects of care. This view reflects those of traditional hospital patients: patients' agreement to sacrifice all aspects of their comfort and control to gain medical safety.

Several respondents had considered using, or actually tried, settings other than hospitals, and decided that the hospital was more adequate because, among other things, it offered a higher degree of safety than the home or the MCA. For past patients of the MCA safety was only one of several reasons for its abandonment. Yet for Debbie, who changed her mind about having a homebirth and opted for a midwife affiliated with a hospital,

safety was the focus of her considerations. She had previously been a patient of a midwifery group at a hospital and had a relatively easy first birth. She recalled:

> We had considered having the baby at home. I myself really wanted to do that, but then I had the miscarriage. Everything went so well with the first baby, that I thought I was on the right track and nothing could happen to me. I got so shaken by the miscarriage that I got a little nervous about having the baby at home, and [husband] was not too comfortable with the idea, so we decided to look for something else.

Midwives' patients were aware of the possibility of complications, but for them they were remote possibilities, albeit ones that warrant prior consideration. Women who opted for hospital birth with a physician, however, tended to see childbirth as a condition in which complications were not only probable but also imminent. They seemed to perceive the potential for complications as higher than did midwives' patients. Laura, the internist who opted for an obstetrician's care, said:

> In the hospital you've got the availability of resources if you need it. Things are just not available outside the hospital, at the MCA or at home. If you start to bleed profusely, you can't be transfused; if you need an emergency cesarean section the time is wasted in transport to the hospital. If you develop some kind of peculiar or rare complication - you are just not there. It's critical, time and expertise.

Other hospital users from both patient groups were less elaborate about the specific complications that could arise, but nevertheless strong in their opinion that "you never know what's going to happen, so you are better off right there" as one woman expressed it. Thus, the view of most respondents who opted for hospital birth, regardless of the type of their attendants, was that the hospital was safe for birth, because of the chance of complications. While for midwives' patients other aspects of care had to be present,

obstetricians' patients were willing to compromise them to gain what they perceived as safety.

In light of their own childbirth experiences, the considerations of women in second pregnancy were different than those in their previous choices. Lisa, who opted for the MCA for her two deliveries, recalled that in spite of her hesitations regarding the loss of control and participation in her care, she had considered using a hospital for her first delivery. She said: "I was more nervous because you don't know what to expect with your first child. I was more willing to go to a hospital." After having experienced a short and easy delivery at the MCA she felt more confident, and while still acknowledging the inherent unpredictability of childbirth, opted for repeat use of the MCA. Nina, another MCA chooser, who had also experienced a short labor, attested that her confidence about the normalcy of childbirth in general and particularly her own, increased. She said:

> Based on my previous experience I would have done it [second childbirth] here, at home. With the first birth I had such an easy time, hardly any pushing and no painful contractions, so I said to myself "this time I can do it in the most natural way, and in a place that is similar to home."

After a childbirth experience the subjective feeling of safety could change in the opposite direction as well. Susan, who had had a difficult first birth and attested to her becoming more attentive to the possibility of complications from other people's childbirth stories, switched from a small community hospital to a large teaching hospital. She said:

> I look at labor differently now. I used to have a lot of physical fears, about my survival. I was afraid that in the hospital they will make a mess of me, that they would use the wrong medicine. This time I do not think about that. I think about all the things that can go wrong, and that puts me back in the hospital. That's how I've made my decision, because I feel the priority has to be the baby and not me as

> the laborer. Although I am important too, but the reason for the pregnancy is to have a healthy baby. It seems crazy to go through the whole thing, and then if there is a problem to not be able to deal with it.

The major aspect of the hospital she chose for her second delivery was the availability of a modern neonatal intensive care unit. As her focus changed from fears about herself to those that centered around the baby, she also changed the priorities that dictated her choice.

In contrast, respondents who opted for out-of-hospital birth saw hospitals as potentially dangerous when complications did not exist. The likelihood for unnecessary interventions to occur as a result of the mere existence of emergency equipment seemed high and dangerous to them. Lisa, who opted to return to the MCA for her second pregnancy and childbirth, said about this issue: "In the hospital if they have certain facilities available they like to make use of their facilities, and much to the chagrin of the people who want to use the hospital on a limited basis." Concern was also expressed about being near sick people and the probability of catching diseases in the hospital. Nina, an MCA user, was concerned about getting AIDS through contact or transfusions. Others spoke generally about the spread of diseases and infections in hospitals and the dangers these pose to mother and newborn.

These views stemmed from a basic assumption of their beholders that they were not sick, that pregnancy and childbirth were healthy and normal conditions, and that they did not need medical care. Their concern of becoming sick as a result of using a hospital for childbirth is all the more understandable from this point of view. Comments like "I am not sick so why should I go to the hospital?" and "its a hospital, hospitals are for sick people, you assume you are not sick" reflect the shared view among MCA users. Hospitals for them were not places for healing or healthy events, but for sickness. They did not see the

need of a hospital for an event that they associated with health. The following comment by Eileen, an MCA patient in her first pregnancy, reflects the views of others:

> Hospitals to me are places you go to when you are sick . . . . It brings up a lot of images of being sick and being a passive patient . . . . Hospitals are not places for healing, they sew you up but do not do much for you mentally.

To summarize, the safety issue has been salient in all women's accounts, and the vast majority saw the hospital as offering safety in case of emergency situations or complications during childbirth. Physicians' patients saw hospitals as safe for all birth conditions. Several midwives' patients saw the hospital as safe for uncomplicated births as well. Respondents who opted for out-of-hospital birth were strongly opposed to a hospital birth if no complications existed. The sources of dangers in hospital birth were excessive use of equipment and medical interventions as well as the spread of diseases. There also was a connection between a woman's beliefs about childbirth and her opinion regarding place of safety, especially as those were affected by previous birth experiences.

Besides safety, patients' emotional and physical comfort were discussed through references to the physical and institutional aspects of the hospital environment. While both obstetricians' and midwives' patients were critical of the physical environment of the hospital, the latter were also familiar with, and critical of, hospital policies and regulations. Tanya, an obstetrician's patient in her second pregnancy, said of her state of mind regarding going to the hospital:

> I just hope it does not feel cold. That is the most I can hope for. I have no expectations of it being anything less than a basic hospital . . . . Hospitals are a necessary evil and I would still [rather] be in a hospital than a lesser facility, not that emotionally it might be better . . . I imagine hospitals as horrible; I do not expect it to be anything less than awful . . . from the time you get to the hospital, the

> bureaucracy, the registering. You are told where to go and it's freezing cold in the room and you are in a gown, all those things. My expectations are very low.

In contrast, Sara, the midwife in second pregnancy, commented: "This is not a wonderful hospital, it does not have a fancy birthing room, but the philosophy is there which is a lot more important than the physical look of the place."

Central in discussions of the hospital environment by respondents from both groups was the place of birth inside the hospital. The use of labor or birthing rooms for labor and birth was favored by midwives' patients and several obstetricians' patients, even though these facilities were criticized for their small size and lack of amenities for patient comfort. Women in their first pregnancies, notably those using physicians, were distressed after having visited the hospital (which most of them did late in pregnancy) having seen the actual place for birth. Sandy, who had used the MCA and switched to a physician, said about what she saw:

> Being confined to a cell-like birthing room, where you have to lie in bed, and at the last moment when your child is crowning they whisk you off into the delivery room, with harsh overhead lights and stick your legs into iron stirrups, that really seems like a nightmare to me.

Midwives' and obstetricians' patients differed in their views of hospital birth and what it entails in terms of use of equipment and space. First, while most respondents in both patient groups criticized delivery room setup and practices, including routine use of fetal monitors, IV, and sturrups, they differed in their attitude to them. Midwives' patients sought ways to avoid use of uncomfortable facilities and equipment, while obstetricians' saw it as a given, unchangeable part of hospital birth. Those of them in their second pregnancies, while unhappy with the physical aspects of hospital environment, accepted them as unavoidable and dismissed their importance during actual birth. Second,

midwives' patients tended to be more familiar than obstetricians' with details of hospital policies, while obstetricians' patients offered general comments about hospitals (e.g. "a necessary evil", "torture chambers""). For example, Debbie, in her second pregnancy, described one of the ways in which she and her husband prepared themselves for their upcoming hospital birth:

> We would not want any heroic measures to be taken for the baby, so it is only a problem of a hospital with rigid rules if something like that would happen. This hospital has its rules like every hospital but if you are clear about your wishes, and you make them clear in advance, if you have it written in advance in your chart they don't hassle.

The reason for the differences between the two patient groups may be that they did not hold the same basic assumptions about the hospital environment and patients' role and possibilities in it. Typical to obstetricians' patients was a general critical perspective on the hospital physical environment, while for midwives' it was hospital policies either solely or combined with the physical aspect. These differences may reflect a different perspective on hospital patients, held by respondents about themselves. The focus of midwives' patients on the non-physical aspect of the hospital environment, which is also more amenable to changes, probably reflects a view of themselves as capable of introducing such changes to the hospital environment. Conversely, obstetricians' patients did not see themselves as capable of affecting the hospital environment, thus focussing on its more tangible and less flexible aspect, i.e. the physical. Clearly, attendants were important mediators in the perception of the hospital. When physicians' patients had specific ideas about the type of birth they wanted, and by implication about the environment, their attendants changed their minds through polite persuasion, convincing women that these were not good or safe ideas, rudely dismissing patients' ideas as foolish, or admitting that these issues were under hospital control and that they could not jeopardize their affiliation by failing to abide

by the rules. In effect, these attendants were agents of socialization for their patients toward the birth philosophy of the hospital. The opposite was the case with midwives affiliated with hospitals. They were perceived as representing their patients' interests in attempting to achieve the most for their freedom and control within the confines of the hospital. They presented hospital policies to their patients early in pregnancy, prepared them for the institution and attempted to bend the rules so that patient comfort would be only minimally compromised. Their patients were made aware of differences between the hospital's and the midwives' policies, and approached their hospital stay believing that their attendants also were their advocates in the hospital. For these women, hospital birth implied a situation with specific characteristics. These included, as midwives' patients, continuity of care and avoidance of unnecessary interventions, flexible hospital rules that would allow them a certain degree of freedom, in addition to the proximity and accessibility to medical equipment and knowledge in case of emergency. Roberta, a respondent in this group said about her choice of hospital and midwifery practice affiliated with it:

> [this hospital] appealed to me because you have the best of both worlds, a somewhat comfortable setting, and the people treating the whole thing as a natural thing. I have the freedom of movement and doing what I want to do, and yet I am there at the hospital so if anything does go wrong my baby would be there. It's a hospital but a specific situation within a hospital.

This distinction may be also reflected in the final difference between midwives' and obstetricians' patients, namely, the tendency on the part of the latter to express their negative views of hospitals more harshly than the former. Being familiar with the hospital and expecting to be able to influence their conditions in it may have contributed to the less critical view of midwives' patients. Obstetricians' patients, on the other hand, saw the unpleasantness of the hospital as unchangeable. Influenced by their attendants, they tended

to avoid becoming too familiar with the hospital, knowing additional knowledge was not going to enable them to affect their hospital care.

Hospitals' lack of concern for the emotional well-being of their patients was an issue raised by MCA users. They referred mostly to separation of the family during and following birth, to putting babies in the nursery, and to restrictions on older siblings' presence. Lisa, who approached a local hospital before deciding to return to the MCA said about her impression:

> My [older] child would not have been allowed in, there is no rooming-in facility. It's still a hospital, they don't want children nearby or anything. It's a nice small hospital, there is nothing wrong with it, but we have been spoiled.

Perceiving themselves as able to exert influence on their care, those who opted for the MCA were adamant about patients' lack of control over their own care in the hospital, and of the power the institution has over them without real commitment to providing adequate care. One of them said, summing up a hospital experience she had in the past: "Hospitals are out of control." This group, in general, found hospitals to be unsuitable places for childbirth. Eleanor, in her first pregnancy, said cynically: "Formaldehide, what a pleasant aroma to associate with the birth of a child." They believed they found a place for birth that provided comfort and control without compromising safety. They did not distinguish between different situations inside hospitals and saw no difference between having a midwife or a physician in attendance.

The two women who opted for homebirth were critical of hospitals as well. One of them, Joanne, was against using it under any circumstances, convinced it could not be a safe place for childbirth. She was particularly against the frequent use of medications and surgical procedures in uncomplicated births. The other, Glenda, a nurse who was working

at a hospital, was against it for reasons related to freedom of movement and to comfort, both of which she saw as important for avoiding the development of complications and as compromised in hospital deliveries. They both believed that for themselves, and especially in light of the normalcy of their pregnancies and extensive experience with others' births (both had wittnessed and assisted in deliveries), they had made the right choice, not compromising any of the issues that were important to them.

The Maternity Center Association

The common view among MCA users was that comfort and control could be achieved together with safety outside hospitals. They differed from women planning homebirths in that they had a need to be away from the home in a place that they believed to be equipped for unforeseen complications during labor or birth, and thus safer.

Among users of the MCA there were both satisfied and dissatisfied respondents. Satisfaction was the result of providing a successful combination of safety and comfort, embedded in the physical aspects of the MCA environment and its policies. The aesthetics of the MCA physical environment, its location in a nice neighborhood, and its comfort oriented amenities (e.g. the large shower, the kitchen), were one source of satisfaction. Another source, discussed more thoroughly and emphasized more, however, was the philosophy behind the care. The general view of childbirth as part of the normal course of life rather than a medical event was seen as the factor behind the attempt to provide home-like, yet safe, conditions for childbirth. Lisa, a second-time patient said about that combination:

> They do have facilities there that would have handled the emergency if one arose quickly and competently . . . I like the home-like atmosphere of the facilities, the fact that we had peace and quiet . . . The MCA does try to make it more homey, in that respect it's much more comfortable there, not so hospitalized, not so many

> impersonal people, but it's a sterile environment which is important in the birth as well.

Women in first pregnancies were satisfied with the extent to which the care was aimed at their husbands, not just themselves. Eleanor, a patient in her first pregnancy said about this issue:

> In the beginning I also liked the fact that I never had to push [re the husband getting involved] because the center pushes, just the atmosphere of the center makes it very clear that you are a [ ] if you don't come to these things with your wife. They don't really say it, it just worked out.

Sandy, who later switched from the MCA to using a male physician in a hospital, said about this aspect of the MCA care: "at the MCA he felt at first that he could participate; that was attractive to both of us."

While several patients felt they had a high degree of control over their care, others felt they actually lost control or that the proclamation for real participation of patients in their care were unfulfilled when a real decision about the care had to be made. Although not stated directly, MCA users seemed to be making comparisons between that institution and other possible settings, the home or the hospital. Those who compared their care to obstetricians' care and a hospital delivery, expressed satisfaction at having free access to all parts of the building and to their own medical charts, and their participation in the management and decisions regarding their care. Eileen listed the aspects of care that she felt she had control over and which were important to her and her husband:

> You do some of your own exam, your urine . . . You are actively involved which is also nice . . . You are given free access to go anywhere in the building except if someone is giving birth you cannot go downstairs, but you can go in and look in your chart, do your hematocrit if you know how.

Eleanor, another patient, said about her considerations in choosing the MCA:

> I wanted to be more in control, that it would be a situation where I would know what's going on; that it would be a matter of course that I would be consulted, instead of a matter of course that I would not be consulted, and that is very important to me . . . I wanted both of us to know what's going on at each stage of things.

Lisa, who planned a second birth at the MCA simply said: "It's a way of taking a more participatory part." Those who felt the promised control was actually missing from their care, were making comparisons between MCA care and other forms of care where more control is given to patients, or with their own expectations from the MCA for higher degree of control. There were several issues about which users of the MCA had no choice, and which drew complaints from them. Having to use the medical backup arrangements of the MCA in case of transfer due to complications in pregnancy or birth was a cause of concern. This was one of the reasons that made Sandy, a first pregnancy respondent, eventually leave the MCA. She recalled:

> When I learned that [in case of transfer] I could not use my own backup physician, that was the breaker. I did not understand why. I was very annoyed at that, I understand it was done to protect me, but I suddenly felt locked in. I was going to have to choose from their three doctors.

Her inability to coordinate an HIP physician backup while under the care of the MCA, resulting from refusal of at least one of these establishments to cooperate in her care, was a source of concern for Eileen, who had no other private medical insurance. As an HIP-insured patient, if she remained at the MCA and an emergency situation arose, she would have to bear the hospital expenses out-of-pocket. It was a cause of tension that was not resolved until the last moment.

Another source of tension for MCA users was its screening policies and procedures which also were perceived as indicative of the lack of control. Probably due to the pressures put on the MCA by the medical and the insurance establishments, the center has adopted stringent screening policies, some of which entail undergoing prenatal diagnostic tests. Women found themselves under pressure to reach certain levels of substances (such as hematocrit or glucose) or they could not deliver at the MCA. Accounts of MCA users included concerns and tensions regarding the prospect of being transferred to someone else's care late in pregnancy or during labor after establishing relations with the midwives. In this context, there were complaints of rigidity in the care and unwillingness to see the individual beyond the prescribed rule. Kim, who ruled out returning to the MCA for her second pregnancy explained that previously she was turned down by them because of going into labor one day before starting her 37th week, the earliest time at which a woman can deliver at the MCA. As did others in situations where policies were strictly enforced, she saw the midwives' decision to transfer her as reflecting unnecessary rigidity, especially in light of her having an otherwise healthy pregnancy. Having been sent out to seek her back-up physician while in active labor made her confident in her choice of the hospital for her second delivery, where, she reasoned, she knew she did not stand the chance of being transferred.

The very use of prenatal diagnostic procedures, several of which were made mandatory at the MCA, was a source of tension for its patients. Undergoing repeat glucose tests which necessitate fasting and spending long hours at the MCA reflected, from users' point of view, lack of concern and empathy with the life circumstances of women who had young children at home to care for. For women who were otherwise clearly healthy, this practice reflected rigidity and negated midwifery care. It was in response to such tests that women voiced their only complaints about the nature of MCA care. There were complaints about pressures from MCA midwives to undergo an alphefeta protein test and

an amniocentesis even though a document had been signed stating the lack of interest in knowing whether the fetuses were disabled, and that they would not be aborted if they were. Lisa attested to having been pressured by MCA midwives to take amniocentesis because of her age (36) and contrary to her preference, and encountered ridicule when she called to find out the amniocentesis results after four weeks. Taking amniocentesis is not mandatory according to New York State law, yet it has become common practice to offer the test, especially to women over 35. Making the decision whether to take this test or not is a painful process, regardless of whether the final decision is in favor or against taking it (Katz-Rothman, 1986). A problem arises when attendants put pressures on patients to make decisions in line with an external social norm, yet which are against the patient's own judgment. Pressuring women toward making the "right" choices with regards to technological and other advances, which are actually ethical decisions, is discussed extensively by Katz-Rothman (1984). Midwives' putting such pressures on them was particularly disappointing to those who opted for the MCA.

Finally, the large number of midwives in practice at the MCA was a cause of concern for women regarding the possibility of being assisted at the birth by someone they hardly knew. If they saw different midwives each time they complained about not seeing enough of any of them. When they saw the same one(s) the complaint was about not getting a chance to meet some of the other midwives at all. Patients were clearly dissatisfied with the large number of midwives at the center.

The complaints mentioned were voiced by women who had left the MCA but also by users who opted to remain under its care. The latter experienced tensions regarding transfer and also voiced complaints about rigidity of policies. While highly satisfied with the high degree of participation and the comfortable environment they also were aware of the unavailability of other out-of-hospital services to choose from, and opted to stay at the

MCA. What Nina, a patient in her second pregnancy at the MCA, said about it reflects its common view among patients: "Now, close to the end, looking back, I feel that of all the possibilities open to me, this is the most suitable, this was the best compromise."

Women who opted for hospital care, whether with a physician or midwife, were divided in their views of the MCA. The dividing issue was safety, which seemed satisfactory to some but not to others. A group of women were adamant in their opposition to childbirth outside the hospital under any circumstances, which they saw as "unwarranted risk taking." These were women for whom the possibility of an emergency developing during childbirth seemed real. They focussed on the need to transfer to a hospital in such a situation, and that led to their perception of the MCA as equal to homebirth, which they also opposed. Hospital users who did not express outright rejection of out-of-hospital birth, still saw the emergency backup arrangements of the MCA as inadequate. The equipment available at the MCA seemed insufficient to save lives, and the hospital with which it was affiliated too far. On the other hand, choosers of hospitals who did not feel there was an inherent risk in giving birth outside a hospital could focus on other aspects of using the MCA, which they overwhelmingly saw as positive. The nature of midwifery care and the close cooperation with physicians were perceived as a combination of comfort and safety. The nice physical environment was also mentioned by several women as more adequate for childbirth than the hospital's sterile surroundings.

Overall, women planning hospital births with midwives tended to be more favorable to the MCA than physicians' patients. They compared it to the hospital from various aspects, including the home-like environment, which was better than the hospital's, and patient control which they saw as lacking due to the perceived rigidity of the MCA's institutional policies. The safety issue was seen by these women as something that was well taken care of. Compared to physicians' patients, midwives' patients in hospitals

seemed to refer to emergencies during childbirth as a remote and unthreatening possibility which probably contributed to their greater readiness to accept the emergency arrangements of the MCA. Obstetrical patients, on the other hand, seeking preparation for emergencies which seemed imminent, were less willing to accept any arrangement other than the equipment and medical knowledge of the hospital. This group, however, was more divided in its views of the MCA than the group of hospital midwives' patients.

The Home

The option of a homebirth seemed attractive to women in all user groups, mostly because of the comfort and fulfillment of emotional needs that it seemed to offer. Yet most respondents rejected it as unsafe. Only three were confident about its safety; two who actually planned a homebirth, and one MCA user who rejected this option because of her living conditions.

The two issues that came together when the home was discussed as a place for childbirth were pleasure and safety. For almost everyone, birth at home implied comfort and emotional security. There was, however, diversity in the way safety issues were perceived. And while a group of women felt that in spite of the comfort offered by homebirth they had to dismiss this option, others sought ways to find both safety and comfort in it.

The two women who opted for homebirth, both of them in first pregnancies, differed in the meaning of safety in childbirth. For one of them, Joanne, the home was safer than the hospital under all circumstances, normal and complicated alike. The other, Glenda, saw the hospital as beneficial in emergency situations and unnecessary for uncomplicated birth, in which case comfort took precedence over access to emergency

equipment. Making advanced arrangements with a hospital close by, and being under the care of a physician throughout her pregnancy along with her midwife's care (and as the latter required), seemed to her satisfactory to achieve safety. Comfort during labor and birth was mentioned as important to both women who opted for homebirth. Glenda sought to avoid the treatment patients receive in hospitals, particularly hospital policies that she found counterproductive to good labor management, such as transfer between locations during labor and birth. For her, comfort and control were not separable:

> In normal birth I think about a place with comfortable atmosphere. Some women feel comfortable in a hospital sterile situation with the lights up, I do not . . . . If all is OK I prefer to be home, I am comfortable here. I know I can do things here that I cannot do at the hospital as far as walking around or moving my positions. I heard hospitals saying they are getting into that now but I also heard that nurses still tell women they cannot do this or that and they have to stay in bed now; it has to be such that you are able to do what is comfortable for you.

For Joanne comfort also meant spiritual fulfillment that she was only able to find in her home, and toward which she prepared herself carefully:

> We picked this place, by the ocean, we moved here especially for the pregnancy and the birth, close to the beach. We wanted such proximity to the ocean because I liked the idea of giving birth close to the ocean. We knew we would go to the beach frequently to breath in the fresh air, which we do. I envision doing part of my labor on the beach, we both have an affinity to the ocean; its a place of peace, and it seemed like a nice place to give birth. The child will appreciate it when it's grown, that it happened near the ocean.

Emotional needs and comfort were high in importance for respondents who actually chose the home for their births. They felt they indeed achieved them without having to compromise others.

In spite of being generally in favor of using the home for childbirth, MCA women had some reservations about it. Concerns were voiced about safety, and also about issues of comfort and control. All of the MCA users in the study had considered seriously having a homebirth, and they all said or implied that their final choice - the MCA - was the best compromise between what the home and what a medical institution offered. Often it was the issue of safety which finally made women give up the homebirth idea, though one of them, Eileen, admitted that safety depended on a subjective perception. She said about comparison between her home and the MCA:

> I think homebirth has its risks, every place does. The MCA is not much safer than home, actually, they don't have lifesaving equipment there. Given the proximity we live to a hospital I do not think the MCA is any safer.

Nina decided against the home as the place for her second childbirth primarily because of her living conditions (a small, crowded, basement apartment), which she did not see as suitable for birth. She said:

> The most preferable thing would be to do it at home but I did not think our home is suitable for that. Because it is very crowded, very small . . . . If I had a larger home, with sun, air, something nicer, I would have done it. But with this apartment the MCA is the home environment I am looking for.

She was not concerned about safety, expressing confidence in the normalcy of her pregnancy and of childbirth in general, especially following her previous short, easy labor. The others, however, felt the home was not suitable as it did not offer the safety they perceived necessary for childbirth. Kim, also in her second pregnancy who had used the MCA once before, said:

> Not everything can be done in a home to feel that that's the best environment. It is not necessarily the best thing, because even in a homebirth everything has to be clean and sterile and I don't think that's a sterile environment, [though] it may be a homey environment, it may make you feel comfortable.

Issues of comfort and control were present in the account of Eileen, an MCA user in her first pregnancy:

> [homebirth] is private, more personal, you are in total control . . . . We can have whoever we want there. It would be so familiar, we have lived here for years . . . . It will also ease the tension.

Thus, MCA women were not far from homebirth women in their perception of homebirth regarding the importance of comfort in childbirth and the possibility of achieving it safely. They differed, however, in their views of safety arrangements needed in childbirth, feeling that although it was not essential for normal birth to be in a hospital, it was not wise to be too remote from it or to stay home. They would rather be half-way between the home and the hospital.

Women planning hospital birth, regardless of the type of attendant, made favorable references to homebirth with expressions such as "probably the best possible experience" or "the nicest thing possible" and said that their own beds, at home, were indeed their immediate image of childbirth. Yet they added that although homebirth was attractive because of the comfort and emotional fulfillment it offered, they did not see it as a realistic option under today's conditions, since they perceived medical advancements to counter the potential dangers of childbirth. Most of them rejected it outright because of dissatisfaction with home safety for birth, seeing it as inadequate due to lack of immediate access to medical knowledge and facilities for emergency situations. Susan, in her second pregnancy and who opted for an obstetrician affiliated with a large teaching hospital, felt the homebirth option was not really open to her because of constraints imposed by the insurance industry, which favors hospital confinement and reimburses it more generously. A homebirth would entail a lot of expenses she could not bear, especially in the case of an emergency.

Aspects of homebirth that seemed attractive to women in all groups were mentioned negatively by several respondents planning to use the hospital, with a midwife or a physician. Having control over the situation was recognized as valuable but the responsibility involved in it was scary to Roberta, in her first pregnancy, planning a midwife-assisted hospital birth:

> What appeals to me about the home is relaxing and letting nature take its course and not worry about getting used to a new environment. The only thing is that it is scary . . . . Even though if I had a homebirth and have midwives with me who I would trust, I am still depending on myself, more than anybody, which is scary . . . . It appeals to me to be at home and do it my way but I don't know what that is yet. Maybe the second time.

Several hospital users saw unfavorably the possibility of sharing childbirth at home with family members other than the partner or with friends, as an essential condition of homebirth rather than an option that it offers. The presence of older children was particularly opposed, but there was also a general discussion about the loss of privacy. Grace, the mother of twins, said:

> I do not believe in family birth, or that children would be exposed to it . . . . There should be places that specialize in it. To me giving birth is not a natural wonderful thing, it is a private thing. There are too many things that can go wrong in a home. There is no reason today to do that.

Ann, also in her second pregnancy, said: "There is no appeal for me in doing it in my own bed with friends and relatives around . . . . Privacy goes down the drain at the hospital also but it is still preferable." Ellen, another second pregnancy respondent, preferred the hospital over the home partly because of the negative associations childbirth had for her:

> Giving birth is not the most comfortable thing in the world to do and I would not feel comfortable doing it at home. To the contrary, I want to be away from home, I want good memories from home. I want this part of my life [the birth] somewhere else. Because you never feel comfortable, and you are in pain, and with another child at home, I think it really is looking for trouble.

Several hospital users perceived the post partum period as more beneficial at the hospital than at home. They weighed the prospect of being home immediately after the birth with a newborn and sometimes an older child against the hospital stay in which they envisioned themselves as rested and taken care of, and opted for the latter. Said Ellen:

> For me the thing that overrides everything is the hospital stay, when the hospital doctors and nurses take care of your child. It gives you time to relax and get back to yourself. It is very important, it gives you a big push to return home. With a second child you want to be away from home and the responsibility at least for three days so you can get back to yourself and be able to work twice as much when you return.

As already mentioned, while comfort and control-related issues were discussed by hospital-birth women, these issues were not central in women's decisions to reject the homebirth option as vehemently as they did. Obstetric patients saw the unpleasant aspects of hospital birth, i.e. loss of comfort and control, as inevitable if they wanted to achieve safety, and thus their view of homebirth was of total rejection. Seeing the hospital as safest in all situations of childbirth, they could not comprehend the emphasis homebirth women placed on other issues. Several women planning hospital births and using physicians perceived comfort as equal to safety, and dismissed any other meaning it had, as presented by others or in books and childbirth classes. The following comments by women from this group demonstrate this tendency: "For me, a wonderful birth experience is bringing home

a healthy baby, not staying at home and insisting on a homebirth in the face of obvious signs of a disaster."(Grace). "The advantages regarding the comfort of the environment, the ease of bonding with the child is trivial, it might have minimal advantage, but undertaking any risk for that is unwarranted."(Laura, the internist). Said Nora, the obstetrician:

> The actual setting of the birth is not important to me, [that] there have to be pictures on the wall and a rocking chair. Having a healthy baby is what's important to me and I think you can accomplish that by either being in a place like a birthing center or in a hospital, but I would never do it at home.

Patients of midwives rejected the home option for birth since they felt it was possible to achieve comfort and some control inside the hospital without compromising safety. They were thus looking for a "homey" hospital environment yet in doing that were focussing on the policies and regulations of the hospital rather than its physical setup.

Post-Decisional Reactions

At the time of the interview, respondents were at the point of having experienced the implications of their choice in one area, i.e. prenatal care, but not in childbirth. They were thus able to report about their post-decisional reactions only in regards to pregnancy care experiences. While Janis and Mann (1977) saw the post decisional stage as primarily involving conflicts that need to be settled, the women in this research, were aware of both the shortcomings of their choices, but also of their reality and were not necessarily in a state of conflict.

Rather than divide the women into groups according to the particular responses that they made, it is useful to discuss the range of responses to choices that were made, , since there was commonality among respondents who differed in their post-decisional reactions.

The reactions varied between regret about the choice, where women discovered unexpected shortcomings in the services of their choices and blamed themselves for not having acted differently, to acceptance of the situation, to satisfaction with their choices. The common aspect in all of the women's reports was the incorporation of comments about their awareness of factors inherent in reality both regarding their personal situation and the available services, that justified their choices and did not permit making others.

The extent to which women expressed disappointment with their services of choice was related to their expectations and the degree to which they had taken into consideration at the time of choice the actual features of the service. The further the expectations from reality, the harder the disappointment. Thus, two MCA patients, whose expectations were for a non interventive, participatory care, were disappointed to reveal that in reality it was not such. Obstetricians' patients who had strong desires for particular aspects of care, e.g. high involvement of doctor with patient, or who had preferences that were incompatible between themselves (e.g. for a "natural" approach to care, yet also for immediate medical intervention if emergency situations are suspected), also experienced strong disappointment as reality unfolded. They found out that they could not receive care from a specialist affiliated with a teaching hospital and still be consulted about core decisions. Women in first pregnancies who were planning hospital deliveries were dismayed at the sight of hospital labor and delivery units.

A common reaction to the women who experienced such gap between their expectations and reality was a combination of resentment and acceptance. In contrast to the approach Janis and Mann (1977) utilize, in which a reaction of acceptance and focus on positive aspects of the chosen alternative ("bolstering") are taken as a tactic to reduce cognitive dissonance, I see it as a realistic approach to the constraints of the situation. Women were aware that their ability to switch services was largely limited after the 5th

month of pregnancy. They did not seem to exaggerate the advantages of using another alternative. Instead, they recognized the positive and negative sides of the alternatives that had been acceptable to them, and realized that in light of the complexity of the services and their own situations, and the limitations posed by the reality of the health care system, choosing another service might not have been more satisfactory in all respects anyway. Comments like: "I am not sure that had I chosen another practice, I would have gotten better care," (Dorothy, first pregnancy, opted for male obstetrician) "I do not see that I miss much; I feel I am getting good, concerned care from this obstetrician just like from midwives" (Sandy, first pregnancy, changed from the MCA to a male obstetrician), and as quoted earlier, Nina, the MCA patient in second pregnancy who summed up her experience with a realization that in spite of her disappointments, out of the options open to her, this was still the most acceptable one.

The women who were clearly satisfied with their choice of service were those who opted for homebirth, and those who opted for midwives' care in hospitals. Respondents in these two groups did not feel they had to compromise anything in order to achieve their objective for prenatal and birth care, and were not surprised to discover unpleasant aspects in the service of their choice as they approached the end of their pregnancies. Common to the two groups is the attendant, i.e. midwives, who were practicing independently (as opposed to MCA midwives who are part of an institution). The services chosen by women in the two groups had in common the diminished degree of institutional quality, compared to the alternatives chosen by the other groups. Those who opted for homebirth had little by way of institutional qualities to encounter, i.e. the policies of their midwives for handling complications, and in case of transfer, a need to deal with hospital regulations. Midwives affiliated with hospitals prepared their patients extensively to dealing with the hospital, and with hospital regulations, so that they knew many details of hospital policies and how they could be dealt with to maximize the comfort and ensure getting the care they wanted. As a

result, these respondents did not see the institutional qualities of hospitals as negatively and as threatening, but rather perceived themselves as capable of handling the situation, especially with the support they expected from their attendants. Thus, compared to women in the obstetricians' and the MCA groups, those in the homebirth and the midwife/hospital groups were most satisfied. The above interpretation demonstrates that it was not merely the type of attendant or of a place that determined the perception and satisfaction with a service, but the specific combination of both.

Conclusions

The most important aspect of a place for birth was safety. However, since its meanings varied among respondents, it led to various perceptions of settings, and resulted in different choices. Variation was so large that the same place, the hospital, was perceived by some women as the safest and by others as offering the least degree of safety for the same event, uncomplicated birth. So was the situation regarding homebirth. The choice and perceptions were less influenced by aspects of comfort and least by the degree of control a place offered. The two issues were played down by some but others who felt they achieved safety adequately pursued comfort alongside with it.

Safety, Comfort and Control

Three issues were expected to underly women's choices of services for prenatal care and childbirth, namely physical safety, comfort or the fulfillment of emotional needs, and control. Indeed, I found them in the process of choice, yet in somewhat different ways than expected. First, I identified a hierarchical order of importance among them, which I had not anticipated. Safety was most important to everybody, followed by comfort, and finally control. Second, only safety and comfort were sufficiently salient to be addressed directly by respondents from all pregnancy and user groups. Control was addressed directly by a small groups of respondents; aspects of it were inferred in others' accounts. Third, an examination of women's perspectives on these three issues also revealed that each one had multiple meanings, shared by groups or limited to individuals. Finally, women tended to weigh the safety, comfort and control issues against each other while constructing perspectives on pregnancy and childbirth and on services. This weighing process was central to the choice. Choices among services were, in effect, choices among issues according to individuals' perceptions and priorities.

Meanings of Safety, Comfort and Control

Safety meant to all respondents avoidance of physical dangers during pregnancy and childbirth. The same reasons that made it salient in the literature and advocacy of childbirth management procedures, that historically had been directed at women in attempts to influence their opinions and choices, may have made it salient in respondents' accounts as well (Ehrenreich & English, 1973; Shorter, 1982; Wertz & Wertz, 1979). Although the comfort issue had also been used in the past to lure women to the use of certain procedures and facilities (Wertz & Wertz, 1979), safety has a component of fear in it that has proven in the past to be of utility to those who used it (Devitt, 1977). For example, early in the 20th century the medical establishment attempted to persuade women to replace midwives by

physicians as birth attendants, by describing the latter as dirty and uneducated, which made them a hazard to women's health. Indeed, based on respondents' accounts, fear was still present in women's consciousness in favor of or against certain facilities and procedures. The meaning that has been attached to it and used most commonly in the history of childbirth practices is that of medical safety, stressing that medicine can offer the sure ways to gain safety. Historically there have been opponents to this view, as there are today, both in the literature (Kitzinger & Davis, 1978; Oakley, 1980; Stewart & Stewart, 1976) and in women's voices. Indeed, respondents varied in the meanings that physical safety in pregnancy and childbirth had for them, which is reflected to a degree in their choices of services.

Variation was found in the emphasis on mother or baby in opinions about safety of services and procedures for pregnancy and childbirth. Along with addressing safety as a general issue for childbirth, a number of women also referred specifically to the safety of the baby as a concern around which they were making choices. Those in second pregnancies mentioned that their safety concerns shifted from themselves to their babies in the second pregnancies. They were able to name a number of complications and possible dangers to their babies, which they sought to avoid. This can be seen as part of the general tendency among women in second pregnancy to focus on the baby and not on themselves and their pregnancy. Since there was no consistency either among the women and within the individual accounts with reference to the object of safety, and since there is no inherent conflict between safety for mother and baby, here safety is referred to in general.

Achieving safety meant being in a situation with facilities and people around, or accessible, to take care of physical dangers. The meaning of physical safety was related to whether birth was seen as an inherently dangerous event or as one that could develop complications but which usually did not.

Medical provisions, i.e. physicians and hospitals, were perceived as most adequate to handle complicated childbirth. Yet for birth without complications, respondents who opted for birth outside hospitals saw the use of medicine as possibly or inherently dangerous. This view referred to excessive use of interventions and misdiagnosis of conditions as dangerous when they were not, with incorrect treatment consequences. For example, the use of ultrasound during labor as a diagnostic tool by medical students and residents not sufficiently experienced and/or confident in the interpretation of its findings was mentioned as leading to incorrect recommendations for cesarean sections when not warranted. When a situation like this occurs during pregnancy, as happened to one woman in the study, another opinion can be sought (as this respondent indeed did) with the hope of getting a different interpretation of the results. During labor, however, women are not in a position to argue or seek ways to influence decisions and thus have the least control over their care. This was a concern that connected the safety and control issues.

Comfort and fulfillment of emotional needs were perceived both by respondents and the literature as secondary to physical safety. As Shorter (1982) commented, it would not have been possible to attain pleasure until death from childbirth, and fear from it, were not dealt with. Yet this is precisely why Oakley (1983) recommended a shift in priorities; she argues that it is because the danger of death in childbirth has disappeared, that attention should be given to the quality of the experience rather than to its inherent physical dangers. There was tension between opinions about the two issues among respondents, as well. While a number of them saw the necessity to sacrifice comfort in order to gain safety, others did not, and sought services that could satisfy their needs for both safety and comfort.

Compared to safety, comfort and fulfillment of emotional needs in prenatal care and childbirth were less coherent and in respondents' accounts. They had multiple presentations, and were not as concrete as was physical safety. Women referred to it in various ways. For example, they discussed having "a good birth experience" without pain, the pleasure of being together with their partners and older children, the comfort offered in certain places because of their physical structures and peace and quiet, and the fulfillment of spiritual needs. This concept stands for the psychological realm of the birth experience. Compared to physical injuries which have clear appearances in most instances, emotional ones were related to individual inner needs. They were less valued than those in the physical realm, and thus were difficult to discern from other issues and it was harder to construct a concept from them based on women's reports. Yet they were especially salient for two groups of women. One was of those who valued them highly enough to assert such needs; the other included those who devalued them to such an extent that they did not discuss them at all or mentioned their low value.

Control had multiple meanings as well, and the potential for gaining it was perceived as present in a number of areas. Not all of the meanings and areas were addressed directly by respondents yet they surfaced through the overall analysis of the accounts. Often, the same respondent referred to more than one meaning or area. The first and most common area was control over labor pains, and the individual's reactions to it. This was the meaning that women often obtained from childbirth classes and from books about pregnancy and childbirth. It also was the area that seemed to women most attainable, since it depended on themselves and their individual ability to cope. In addition to the labor itself, the other large area to which women referred was the care that they received. Control meant involvement in decisions about care and the execution of the care itself. Women saw themselves as having control over their care when they were able to choose how frequently they wanted to come to prenatal visits and also when they were doing their

own urine tests. Not having control was implied, for example, when women realized that they could not decide themselves whether they could remain patients of a service in light of results of certain prenatal exams (specifically glucose and hematocrit tests, at the MCA), in other words, that their desire for a type of care, expressed through the choice, was not respected in practice. Having control over their care meant, to several women, having freedom of movement and activities, not being coerced into specific positions or subjected to institutional policies of labor such as the use of IV instead of taking in fluids orally, or using a fetal monitor. Participation in core decisions about care, such as those made in the face of possible trouble (e.g. the choice of method to deliver a baby that seemed in distress or whether to do a CS if there was question about the possibility of breech vaginal delivery) was something that the majority left to their attendants, physicians and midwives alike. Such an attitude was justified by the professional knowledge available to the attendant.

If having decision-making power is what control means, it is clear that respondents had very little if any. They could influence their care to a degree, through the choice of service or constant attempts to affect those who had the power in reality, i.e. attendants. Yet not one respondent actually believed she had no control; they clearly held the belief, that they had the power to control areas of their care and accepted the idea that the rest could not possibly be in their hands. The concept of perceived control (Gatchel, 1980; Langer, 1983) provides an explanation for their beliefs and actions. This concept refers to the subjective belief of having the power to control the environment. And, indeed, actions that resulted from the belief in having a measure of control, did have positive effect on respondents. Grace, in her second pregnancy, reflected on her successful attempts to change a decision to deliver her twins by a cesarean section, concluding that during her second pregnancy she lost all control over her care. Susan, who pointed at policies of the insurance industry as sources of limitations on her freedom of choice, still believed she had control over the nature of her care. She believed that by gaining knowledge she could

make a better choice than in her fist pregnancy, one that would provide her with the type of care she desired. Upon realizing that hospital policies were different than what had been presented to her when she made her choice, she tried to influence her physician by bringing him a book about the Bradley method. Reflecting on her beliefs and actions she said: "Since I brought him the book he promised me to buy and read it; I don't know if he did but it made me feel more comfortable." Thus, while admitting she probably accomplished little by way of actually changing her care, it was her acting as if she had the power to do that, which was more important and led to the improvement in the way she felt about her choice. The concept of perceived control can also explain the beliefs and activities of MCA patients, and of women in first pregnancy who believed that breathing and relaxation techniques would control their labor pains.

The distinction between actual and perceived control is not sufficient to understand the situation of women and their actions in this research. A further distinction is needed, between control on an individual level and that on a structural level. Respondents' actions in attempts to influence their care were real for them, and were done in a genuine attempt to influence their own care. However, they were only able to influence their individual situation, and only to the degree that their desires and actions did not conflict with the philosophy underlying the health-care system as a whole. Thus, it is structural control that they lacked, and even those who opted for maximum responsibility for their situation, i.e. homebirth, still lacked it, if they wished to get any health care at all (agreement to go to the hospital if the midwife diagnosed a complication was a condition for her acceptance of their care).

The three issues interacted such that their meaning and importance were revealed when two or more of them were presented together or in contrast to each other. When this

type of interaction took place, it appeared with regard to the perspectives on childbirth and services, and as such revealed the meanings of the issues in choices.

Relations Among Issues in Choice of Services

The relations among issues are important in understanding the meanings of the three of them, as these appeared in regards to concrete situations and services. In order to understand the relations among the issues of safety, comfort and control on the one hand and services on the other, an additional factor requires consideration, that of an individual's perspective on childbirth. To understand the relations among issues in the choice of service one must consider the perception of the reason for that choice.

Among those who opted for hospital care with obstetricians, there was a group that perceived childbirth as inherently complicated, whether their pregnancy indicated the potential for such complications to occur or not. This group of women saw childbirth as dangerous under all circumstances; for them, childbirth was not inherently unpredictable, but rather they held expectations for a turn of events to the worse. Holding such perceptions of childbirth, choice for these women was actually preparation for the worst. The safety issue, which was important to everybody, was elevated for women who held this extreme view to the point of not considering anything but physical safety in their choice of service. Complications of childbirth were salient in their views, and although conceding that their occurrence was in low frequency, they still saw any birth as requiring the utmost in terms of providing sophisticated medical care. It seemed to them necessary under all circumstances. They were glad to relinquish control over their care to their attendants, to hospital staff and to hospital regulations. They tended to accept the discomfort of hospital use as inevitable and without difficulty. They did not expect their relations with attendants to be a source of pleasure or comfort. Indeed, in several cases rapport was reported to be minimal between physicians and patients and women simply felt they were unknown to

their attendants who were also strange to them. They would rather have better relations with attendants, yet their feelings that obstetricians provided the utmost in professional care necessary for childbirth, thus leading to safety, justified their choice.

Overall, obstetrical patients seemed to relinquish control over treatment decisions, even when they questioned the adequacy of physicians' professional judgement. In such situations there were several ways women could use to influence their care. Those who were content to relinquish control used the option of choice, i.e. switching to another obstetrician to whom their could again relinquish all control. Others, for whom a measure of control over their care was important, used other or additional tactics, which will be discussed shortly. In general, those who valued safety so highly that other issues became totally or hardly existent in their choices, did not perceive their own opinions, as lay people, as valuable enough to challenge directly the opinions of physicians.

In several instances, and in addition to decisions regarding prenatal care, control over decisions regarding comfort was also given to physicians without questioning. For example, when women inquired about the use of birth procedures that were not part of the traditional way of handling labor and birth, such as having a Leboyer birth or using a birth stool that was available at the hospital, the final word on these matters belonged to the physician and was not challenged. The justification for this handling of control over comfort was that it was for the sake of safety. Physicians presented it that way, and patients did not tend to question that opinion. For example, a number of physicians, upon hearing requests from their patients about the use of non medical methods to alleviate pain (e.g. walking around, assuming certain positions during the birth), dismissed them as unsafe. The use of arguments for safety by physicians convinced women that their requests for comfort were not justified, and they did not tend to challenge that.

The women described above, who saw childbirth as inherently dangerous, were not necessarily happy with all aspects of their chosen service. The missing aspect was that of relations with attendants. Yet these respondents did not seem to have any cognitive dissonance or reconsiderations following their choice (Janis & Mann, 1977). This was probably because of their confidence that they had made to right choice to gain safety, the issue that was most important to them.

Other women opted for the same type of service, i.e. physician affiliated with a hospital, yet their choices did not seem completely justified to themselves. Although they considered some change in their choices toward greater liberalism and better relations, such as in midwifery care, they remained with their chosen service, as they were still convinced of the danger inherent in childbirth and the necessity to have professionals whom they valued the most, i.e. physicians. They did differ from their counterparts in the importance they attached to obtaining comfort and control in their care. They were not willing to sacrifice the other issues for safety's sake, yet they found they could not meet their high standards for safety in any service other than the one that also belittled the value of comfort and control. While they did not consider challenging their attendants' judgments, these women had some critical comments about their obstetricians' practices. For example, a few comments were made about the possible negative outcomes of practicing defensive medicine, or of lack of confidence in practice, both of which may result in unnecessary procedures that may harm the patient. Yet these reasons were not sufficient to leave physicians, who were still perceived, as a whole, well equipped to handle birth with and without complications. They also attempted to provide physicians with additional data about conditions, to influence their treatment decisions. The use of such tactics necessitated obtaining ample knowledge about conditions and possible ways to handle them, a path chosen by several women, mostly in their second pregnancies.

The choice among hospitals also reflected the interplay between safety and other issues, mostly comfort, although control issues were mentioned as well. When teaching hospitals were preferred over others, it was because they offered a greater sense of safety; when they were rejected, it was because of the lack of comfort in them, due to the presence of students and residents. When two hospitals which were considered to offer the same degree of safety were compared, it was the sense of comfort that they offered, that made women choose between them. Comfort could be associated with various aspects of the institution and the care it offered. For example, crowding in the rooms made Kelley, who expected to have a repeat cesarean opt against the use of one hospital, because she expected to spend a period longer than the average at the hospital. The deciding factor for Ellen, who considered two teaching hospitals was that one of them was under construction; it was decided to opt for the other hospital for reasons of comfort.

Those who did not share the view of childbirth as inherently dangerous, were making preparations through their choices for both positive and negative turns of events. They attempted to achieve comfort and also control in addition to safety. For them, childbirth had the chance of turning into an event that necessitated comfort and control even more than into a hazardous one. These were the women who opted for midwifery care inside and outside hospitals. Among midwives users, the choice of setting was sometimes indicative of a view about childbirth that emphasized strongly the safety necessities, but in others it was clearly made with an emphasis on control or comfort.

Midwives were perceived as adequately safe by their patients and by a number of physicians' patients, yet it was their relationship or affiliation with physicians and their training as nurses that made them so. In other words, it was the medical component of midwives' professional skills that made them safe. It would have been interesting to see the opinions about midwives who were not medically trained, i.e. lay midwives, but all

midwives' patients in the study were under the care of nurse midwives. It was hard to distinguish the component of experience from the medical training component in evaluating opinions about midwives' safety. This was especially so since a number of women who were not midwives' patients made no distinction between lay- and nurse-midwives. Thus, midwives were perceived as safe, but the safety value was qualified. To a number of obstetrical patients, midwives were not perceived as safe under any circumstances. These were the women who held the extreme views of dangers in childbirth, who focussed on midwives inability, due to lack of training and limitations in licensing, to perform surgical procedures. Since for these women safety was the only priority in care, they did not see any advantage in opting for a midwife. Midwives' patients, on the other hand, placed emphasis on issues of control and comfort in their care. The groups that opted for midwifery care were least united in the meanings attached by their members to the issues of safety, control and comfort. While seeing the possibility for advantages regarding safety in being close to medical facilities in case of emergency, the women who opted for it were also aware of the comfort aspect in their care.

Relations of midwives with their patients provided comfort for this group. These relations were characterized by openness, information sharing and mutual trust, and were thus satisfactory. The comfort in midwives' relations with their patients was also connected to control issues, as a number of women who chose midwifery care interpreted their participation and involvement in their care which they enjoyed, as control. This applies both to women who opted for midwives who practiced independently (affiliated with hospitals or providing homebirth services) and to an extent to those practicing at the MCA. For example, the fact that information was shared with women on reasons and indications for use of procedures in their care was interpreted as a sign of their having a say in their care. Similarly, when midwives prepared their patients for hospital labor procedures, and encouraged them to object to coercion by hospital staff to undergo

procedures such as prep, monitoring or internal exams, the patients not only felt they had control over their care with the midwives, but also that they were controlling their labors at the hospital. Actually, the openness of midwives was interpreted as having control over care, while in actuality the midwives were clarifying to their patients which aspects of care they had control over and which ones they did not.

In contrast to the perspective held by physicians' patients in hospitals, patients of midwives practicing there saw proximity to medical facilities as an issue of comfort of avoiding the need to transfer if complication did occur, as they saw the safety advantage. In regard to the hospital stay, those who opted for midwifery care also saw the possibility of gaining comfort within the institution, because of various reasons. First, policies of hospitals with which midwives were affiliated were considerably more liberal in their policies on labor and birth management than were other hospitals. Also, within the confines of the hospital, midwives' patients were instructed by their attendants and childbirth classes in ways to achieve comfort through movements and positions, among other things. The hospital, thus, did not seem as uncomfortable to midwives' patients as it did to those of physicians.

Among women who opted for out-of-hospital birth, the view was that hospitals were inherently dangerous for childbirth without complications. Childbirth was perceived as a healthy event that needs assistance but no active intervention if indications for trouble were absent. Safety for these women meant avoidance of hospitals and of unnecessary interventions. They considered the tendency of hospitals to use an excess of intervention as potentially harmful, commenting about the spread of diseases and infections in hospitals, and about hospital regulations that encourage the use of hazardous procedures to healthy labors. In addition to the lack of safety for healthy events, they also saw comfort and control, which they valued, as non existent at the hospital, especially under physicians'

care. These groups thus accepted the medical model only on a limited basis, i.e. only when complications arose, signifying the end of the healthy status of childbirth. These women also attached meanings and importance to control and comfort that differed from those of hospital patients under the care of obstetricians. Comfort meant for them the fulfillment of their individual needs, whatever these were, and considerations of these needs by the service. Not separating the family unit when a desire to remain together existed was an aspect of comfort, as were relations with their attendants.

Those who chose to use their homes held strong views on the danger of hospitals if birth occurs without complications. They also were adamant about the advantages of using a midwife over a physician, whom they saw as more likely to intervene in the natural process of childbirth, while midwives were perceived as more willing to "let things take their own pace," especially in the privacy of a home. What distinguished them was the high value they put both on comfort and on control, and the implication regarding responsibility that they were willing to take upon themselves. Staying home meant for women in all groups a way to gain comfort in childbirth, yet its importance was dismissed as safety according to the medical model increased in value. While expressing strong desires for control over their care, the women who opted for homebirth were not different in their gains from their counterparts in other user groups. They stated clearly that they intended to trust the midwife's decisions regarding their care, and her judgment about the possible development of complications and how to handle them.

Matters of comfort were also deciding considerations both for and against homebirth. One of the respondents who opted for it moved especially for the birth to a new place that was to fulfill her spiritual needs for childbirth. It was important to her to be close to the ocean, and she moved while pregnant to a new place close to the beach, which she left soon after giving birth. A respondent who was convinced about the safety of

homebirth rejected that option for herself because of issues of comfort in her small basement apartment, with a very young other child. Also, aspects of it that signified comfort and control to some were seen negatively and were criticized by others. The fast return to daily routine after homebirth was such an issue.

Those who opted for use of the MCA also held the view, similar to other midwives' patients, that childbirth was not inherently dangerous and that proximity to medical facilities was not necessary. Yet for them strong supervision was necessary, a component of care that the MCA stresses about itself and which satisfied its patients. At the same time, these were also the women who were most assertive about the importance of comfort and control in childbirth care. This was a contradiction inherent in the assumptions of women who chose this institution. On the one hand they highly valued control over their care, on the other they opted for a service that places, for various contextual reasons that are political-professional in nature, a strong emphasis on close supervision and on rigid procedures and criteria for care. It was the women in their second pregnancy who encountered disagreements with midwives at the MCA and who realized the lack of their control. However, as long as they were under the care of the MCA, women felt their desires for control were fulfilled. For instance, they received reading materials about certain procedures before deciding whether to undertake them, to ensure that their decision would be informed. Having information about issues was confused by MCA users with having control. However, in terms of actually deciding on the care, i.e. whether or not to take a test, they did not differ in their situation from obstetrical patients, who were also free to decide on taking tests. And like obstetrical patients, those using the MCA were also pressured by their attendants toward making decisions in the 'right' direction, regarding taking prenatal diagnosis tests. On the other hand, patients at the MCA did not see themselves as sacrificing comfort at all as long as they remained under the care of that institution. The nagging tension of being transferred at the last moment to an obstetrician

or to the hospital was present, but not strong enough to change their views of the basic necessity to be away from the hospital with its hazards and discomforts.

Compared to women who opted to homebirth, MCA patients had a sense of security from the availability of some equipment for immediate care of complications in the building. They varied in their views of safety in the home, such that both the opinion that the home was just as safe as the MCA, and that the MCA is safer than home were voiced by them. The MCA seemed to its patients and to several others as an adequate combination (or compromise) offering both safety and comfort. The opinion that the institution was offering safety seemed to have strengthened as a result of the strict screening procedures it employs.

Conclusions

From the above discussion it becomes apparent that the choice actually takes place among priorities in care for pregnancy and childbirth, and not simply among alternative places or services. It was what the services represented in terms of women's priorities in care that women chose from.

Those priorities in care interacted with the perception of factors that need to be decided upon. Safety, comfort and control are inherent in the perception of the childbirth and pregnancy conditions, and in those of services. It is the interaction of them all and the compatibility of the resulting choice with women's more general priorities that determined and structured the choice.

Conclusions and Implications

This research has specific as well as general implications. These touch on the issue of women choices of maternity services, but also refer to more general issues regarding choices and decision-making in real life situations.

This research was prompted partly by the absence of women's perspective from the writings on birth reform and on alternative services for childbirth. Since, as the findings suggest, women's perspective on services differs from that expressed in this body of literature, adding the perspective of users seems all the more necessary. The differences revolve around two points. First, in the literature on choice pregnancy and childbirth are separated such that most of the focus is placed on childbirth and relatively little attention is paid to the months of prenatal care as part of the choice of service. The women in this research did not make such a distinction. For many, the choice was for services for pregnancy as well as childbirth, the two parts considered important in it. Second, while the place for childbirth has prime importance in the choice of service in the literature, for women in this research the attendant was usually more important than the place. On the one hand, advocacy literature may reflect an attempt to make changes in the status quo. On the other, it does proclaim to represent women's views and preferences, and as such cannot ignore their preferences. The difference in preferences is the third point of difference in perspectives between the literature and women. As suggested in the literature review, the dominant view in the literature is of women who seek maternity care that deviates from the mainstream, presenting homebirth as most desirable in all respects over institutional birth. Respondents here did not see it as such; their perspectives revealed prior examination of various aspects of maternity care services. This literature cannot lead to changes if it is not in concert with the views of the group it attempts to represent. Currently, it seems that the views of the majority of women, those who do not opt for homebirth, who do not categorically reject the medical health care system, are not represented in this literature. An

examination of services for childbirth, especially when an attempt for their improvement of their users' perspective is concerned, cannot ignore the reality of people's lives, in which care for pregnancy and childbirth are not separable, and where the attendant is perceived as the central part of the service.

The advocacy literature also does not correspond to the reality of women's lives, where actual control is limited to the individual level. In reality, women cannot have both decision-making power over their care and still receive health care; structural limitations embedded in the health-care system prevent them from having both. The advocacy literature confuses the individual and the structural levels of control, by presenting issues on the structural level, such as treatment decisions in emergency situations, as if they were in the hands of women. Conversely, issues on the individual level, including body control and the choice of one physician over another, are presented by the advocacy literature as if by acting upon them, women can gain structural-level control. The false expectations created among women by the literature, and facing a reality in which it is impossible to gain the desired objectives by implementing the actions recommended in the literature, probably contributed to the alienation of a large number of women from the goals of the birth reform movement. Also, after 15-20 years of attempting both to change services and to educate their users to assume an active role in shaping their own health-care, the time seems ripe to examine the changes, if any, in the views of consumers, and the basis for these changes or their absence.

The three issues, safety, comfort and control, were indeed what women were choosing from, rather than services as such. Women were seeking to fulfill their needs in these three aspects when they were making their choices. Contrary to the birth reform literature, in this research control was a concern for only a minority. And even for the few women who did seek to control their care, the realization that it was impossible was not the

main concern. The majority of women concerned themselves with issues of safety, and at a low second place, with those related to comfort and emotional fulfillment. The perspectives held by women on pregnancy and childbirth, and on maternity services reveal that "the things that can go wrong", be it genetic diseases or emergency situations developing during labor and birth, are salient in women's minds, regardless of whether they see those as a remote or a highly possible development for themselves. Even though most fetal conditions can only be diagnosed and not treated, and the rate of pregnancy and birth complications is recognized as low, the attention paid them is high, resulting in the dominance of an abnormal view of pregnancy and childbirth. Services that specialize in abnormal conditions of pregnancy and childbirth were seen by respondents as capable of handling the normal conditions as well, but not vice versa. This probably underlied, in part, women's lack of concern with control over the core decisions of their care. While this tendency of women can be interpreted as conformity with social or cultural standards, it can also be seen as a reflection of women's awareness that they had no other choice. Non-conformity could be too costly. In other words, women were aware that they could either have complete control yet risk not getting quality health care, or had to sacrifice control to get such care. There was no half-way compromises that were satisfactory from both respects.

Beyond the particular areas of interest in this research, its implications are more general, concerning the way people make choices that are important to them and the way these choices are examined and evaluated. Real-life choices are made in a complicated context, in a process that is embedded in the lives of individuals, and which yields a product that is meaningful within this context. An examination that ignores the life situations in which individuals make choices, cannot capture this process and the full meaning of the choice.

The decision-making literature has tended to focus on product more than on process, and limited itself to examination of issues that seemed relevant to investigators. This resulted in laboratory research that aimed at the simplification of the complexities of real life decision-making, and produced descriptive or prescriptive structures and models that tended to make qualitative distinctions among individuals on the basis of the strategies they used or their final choices. The present research suggests that women, as real life decision makers, cannot be classified as performing a "good" or "bad" role in it. Nor can the quality of their choices be judged according to criteria that are not related to the circumstances surrounding their making. Rather, the quality of choice and the process preceding it should be examined in light of the life circumstances of individuals, in the psychological, social, physical, economic and political realms. It also found that choices were made after a process of weighing alternatives and evaluating implications related to other people in women's lives and for a broad range of issues, not only the one at stake in the choice situation, in line with Gilligan's (1982) and Gerson's (1985) findings. Thus, to evaluate the choice one needs to inquire into its implications on the rest of an individual woman's life, including her health, family, economic situation, and work situation.

Yet merely including contextual factors in an examination of decision-making and the final choice, was not sufficient to understand the meaning of choices individuals made. Nor was an inquiry about the importance the choice had for the individuals making it sufficient for this understanding. Rather, it was necessary to learn which factors were involved for an individual, and the order of priorities and relative importance they had for her. There were women in this research who expressed opinions about childbirth and the appropriate way to manage it that were in complete discord with the philosophy of labor management at the services of their choice. In such instances stated reasons for the choices, could not provide an explanation. Among other things that were influential in such instances were the presence of older children in the family, having a support system

and other technical arrangements for them, the place of residence and the available services there, and the degree of support to her views a woman had from her partner. Thus, one general implication of this research is the need of decision-making research to open itself to the inclusion of contextual factors relevant to the choice, and the relations among these factors. Once these are taken into consideration in evaluating each choice, none seems qualitatively superior or inferior to another. Instead, each choice stands out as unique in light of the particular life circumstances and priorities that it reflects. This point bears particular significance to writings inspired by the birth reform movement. The choice of one individual for a hospital birth is not worse than that of another, who opts for a homebirth. Even if they held the same convictions regarding hazards of excessive interventions in labor and were equally aware of the higher likelihood of such intervention to happen their choices could differ because of contextual interventions and influences. Seen as unique in a context, most choices become appropriate and well justified. All of these are not necessarily limited to women's decision-making but may apply to men as well. This possibility deserves consideration and further research of the decision-making processes involved.

A major assumption underlying decision making theories concerns information and its role in the process. This research revealed that in reality assumptions related to the existence, pursuit and role of information in decision making did not hold. The assumption in the literature is that information about possible alternatives is available somewhere, and once obtained, an informed choice can be based on them. In this research, it was found that not only much of the information relevant to the choice was unavailable to women at the time they needed it, but that it was not freely available to them at any time. This means that choices had to be made --sometimes knowingly-- on the basis of partial information. As a result, alternatives were either unknown to those choosing them, or were thought known, but later were revealed as different than expected. Overall, this is a situation in

which informed choices cannot be made. It may be specific to the health-care field, but it seems to be typical to real life decision-making situations, in which alternatives are not always clearly distinct from one another, and in which all the information, to assure "adequate" choice making, is not available. Investigations of decision-making are badly needed in real-life situations, to address the limitations on information pursuit and lack of control and their influences on choice.

Seeing choices as part of the general context of women's lives, one can also understand the needs of a number of women not to put excessive emphasis on the act of making choices. In actuality, a woman can have a limited amount of energy and resources to devote to a choice of something she perceives herself as having only limited amount of control over. Investigators and advocates alike emphasize the importance of making choices as a way of achieving one's goals. Yet women, and people in general, may be in situations that limit their ability to exercise choice, or exercising their choices to the full extent may be too costly in energy and resources. In this research, several women reported having had the motivation to make adequate choices and knew where to turn to gain information about services, yet they were unable to devote the time and energy to its exercise, because of structural limitations, meager resources, and the awareness of limited control.

The research yielded general implications about women's position in regards to health-care issues and perspectives on care for pregnancy and childbirth. Respondents pointed at subtle and open pressures they were under, in gaining knowledge about pregnancy and childbirth, about care for these conditions, and about the available services from which to choose. Pressures have been identified with two general perspectives, the medical/conventional, and the natural/progressive. The medical/conventional is the mainstream perspective in America, according to which medicine offers the best care. Its

philosophy underlies most of health-care services in this country, as well as insurance industry policies. The high status of doctors, professionally and in the patient-attendant relationship gives their opinions credibility that amounts to pressure to make choices in the direction that is compatible with this philosophy. The natural/progressive perspective on health-care is part of the general tendency in recent years in American society, especially the middle class, to opt for lifestyle that is "natural." The birth reform movement is probably a product of this trend, where natural ways of handling pregnancy and childbirth are considered having the same value or more so than "conventional" health care. This movement inspired the writing of a large number of popular books. The pressures it puts on women are subtle, and were identified as social, as opposed to professional, pressures; respondents were faced with pressures from cohorts and by a general "fad" on the one hand, and by professional on the other. The two perspectives were in conflict, each generating pressures under which women sought information for making their choices. Making choices in these conditions cannot be beneficial for women's ability to choose and obtain quality health care, as they may act out of perceived need to imitate others or adhere to values that are foreign to them. Structural changes in services, such as changes in insurance philosophies, and educational efforts aimed at women may help put choices in proportion and facilitate better ways in which women can gain the care they desire and still have resources left to devote to other areas in their lives.

An unexpected commonality was found in the research, one that points at a possible future direction for research on women's choice making. There was no noticeable difference between the freedom of choice felt by individuals who differed in their financial means. Since the health-care system in which the study was conducted is one that offers more possibilities to those who have the ability to pay, and since the commonality in perception of freedom of choice was found even between respondents whose income level was extremely high and those who were laid off at the time of their pregnancies, this

finding is particularly interesting. It points to the possibility, that psychological factors underlied women decision-making. Such factors may be related to their general sense of being women and the possibilities offered them, to making choices and seeking control over health-care related issues, or a combination of both. Future research is needed to pursue these possible explanations for women motives in decision-making, particularly in health-care.

Appendix A

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Fall 1986

PROJECT OF CHILDBIRTH DECISIONS

I am a graduate student at the Psychology Department, The Graduate Center of the City University of New York. This project is my doctoral dissertation.

The goal of the project is to learn how women choose where and from whom they want to receive their care during pregnancy and birth. In order to include many different perspectives I interview women who choose to give birth in hospitals, at the Maternity Center Association or in their homes.

Conclusions from this study will hopefully be used for planning of childbirth services in accordance with women's desires.

Your participation in the study is greatly appreciated.

If you have any further questions please call me at any time
in my home (718) 793-5088 or office 790-4550/1.

THANK YOU.

Appendix B

Topics Covered in Interviews

I. Explanations about the study

(For women in second pregnancies) Information about first childbirth

Special procedures and tests during current and previous pregnancies

II. Images coming to mind about pregnancy, birth attendants, place for childbirth, birth.

III. Selected service for current and previous pregnancy and childbirth

Considerations in choices

Significant events in pregnancy related to the choice

Changing/considering change

IV. Knowledge about pregnancy and childbirth - sources

Satisfaction with amount

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