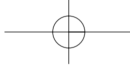
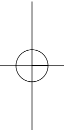
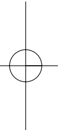
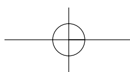
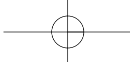
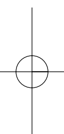
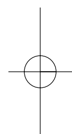
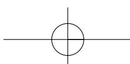


Demystifying Qualitative Research in Pregnancy and Childbirth





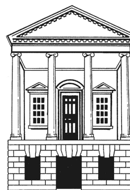


Prelims 9/9/04 3:12 PM Page iii

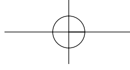
Demystifying Qualitative Research in Pregnancy and Childbirth

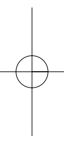
edited by
Tina Lavender, Grace Edwards and Zarko Alfirevic

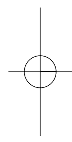


Quay Books
MA Healthcare Limited

Prelims 9/9/04 3:12 PM Page iv







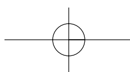
Quay Books Division, MA Healthcare Limited, Jesses Farm, Snow Hill, Dinton,
Salisbury, Wiltshire, SP3 5HN

British Library Cataloguing-in-Publication Data
A catalogue record is available for this book

© MA Healthcare Limited 2004
ISBN 185642 259 3

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without prior permission from the publishers

Printed in the UK by Cromwell Press, Trowbridge, Wiltshire



Contents

List of contributors		vii
Foreword by Dame Lorna Muirhead and Professor Jim Neilson		ix
Introduction		xi
Chapter 1	Why carry out qualitative research? *Carol Kingdon*	1
Chapter 2	What are the foundations of qualitative research? *Fiona Dykes*	17
Chapter 3	What are the ethical considerations? *Donal Manning*	35
Chapter 4	Planning your research *Jane Morgan*	48
Chapter 5	How to collect qualitative data *Denis Walsh and Lisa Baker*	63
Chapter 6	How do you analyse qualitative data? *Bernie Carter*	87
Chapter 7	Embedding a qualitative approach within a quantitative framework: an example in a sensitive setting *Claire Snowdon, Diana Elbourne and Jo Garcia*	108
Chapter 8	Exploring the healthcare experiences of people in hard to reach groups *Yana Richens and Lynne Currie*	129
Chapter 9	How do you assess qualitative research? *Helen Smith*	141
Index		159

List of contributors

Tina Lavender (PhD, MSc, RM, RGN) is a Professor of Midwifery and Women's Health at the University of Central Lancashire with an honorary contract at Liverpool Women's Hospital NHS Trust. Tinalav@yahoo.co.uk

Grace Edwards (PhD, MEd Cert. Ed, ADM, RM, RGN) is a Consultant midwife at Liverpool Women's Hospital NHS Trust and Liverpool and Sefton Public Health Network and Lecturer in Midwifery Research at the University of Central Lancashire. Grace.Edwards@lwh-tr.nwest.nhs.uk

Zarko Alfirevic (MD, MRCOG) is a Professor in Fetal and Maternal Medicine at Liverpool University and Liverpool Women's Hospital. zarko@liverpool.ac.uk

Carol Kingdon (MA Distinction, BA Honours) is Research Fellow in the Midwifery Unit, University of Central Lancashire. Carol.kingdon@lwh-tr.nwest.nhs.uk

Donal Manning (MD, FRCPCH, DCH, DRCOG, MSc) is a Consultant paediatrician, Wirral Hospital NHS Trust; Chair of Wirral LREC and member of North West MREC. Donal.manning@whnt.nhs.uk

Jane Morgan (ADM, Cert Ed, RM, RGN) is a Senior Lecturer Midwifery and Research, Edge Hill College. morganj@edgehill.ac.uk

Denis Walsh (MA, PG DipEd, DPSM, RM, RGN) is an Independent Midwifery Lecturer and Midwifery PhD student, University of Central Lancashire. Denis.walsh@ntlworld.com

Lisa Baker (PgDip, RM, RGN) is a practice development midwife at Liverpool Women's Hospital NHS Trust and MPhil student Liverpool University. lisabaker@cbaker.freeserve.co.uk

Claire Snowdon (MA) Research Fellow, London School of Hygiene and Tropical Medicine. cms1000@cam.ac.uk

Diana Elbourne (PhD) Professor of Health Care Evaluation, London School of Hygiene and Tropical Medicine. diana.elbourne@lshtm.ac.uk

Jo Garcia (MSc) Research Fellow, Social Science Research Unit, Institute of Education, London. J.Garcia@ioe.ac.uk

Bernie Carter (PhD, PGCE, BSc, RSCN, SRN) is Professor of Children's Nursing, University of Central Lancashire. bcarter@uclan.ac.uk

Helen Smith (PhD, MA, BA) is a Research Associate, Effective Health Care Alliance Programme. cjdhel@liv.ac.uk

Yana Richens (MSc, BSc, RM, RGN, SEN) is Consultant Midwife in Public Health, University College London Hospital. yana.richens@uclh.org

Lynne Currie (BSc Hons, Dip.App. Soc. Sci) is a researcher for the quality Improvement Programme and a PhD student at the RCN Institution.

Foreword

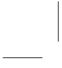
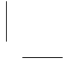
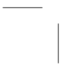
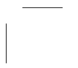
Good clinical research is recognised today as an essential complement to good clinical practice. Without advances in knowledge, practice stagnates, mistakes are perpetuated, and benefits are denied to those who justifiably assume that their professional advisers question accepted wisdom and seek innovation.

In the past, good clinical care could be maintained by adopting the best practices of previous generations and adapting to changing circumstances. As science and technology advanced, there became increasing need for clinical research to validate current practices and proposed developments. Early randomised trials were usually not powerful enough to yield significant conclusions. However, statistical analysis of the combined results of available randomised trials (meta-analysis) has provided important insights into what works and what does not. The prenatal use of corticosteroids is the best example of an effective treatment long under-used, because of the absence of adequate validation of its effects. In the last twenty years, there has been a great increase in the reporting of large, powerful, clinical trials, many of which have changed the ways in which women and their babies are now cared for during pregnancy and childbirth. Quantitative clinical research has had real impact in our specialties, and will continue to do so. Qualitative research, which is often related to perceptions and to matters of personal choice, has emerged more recently, and is less well understood.

The choice of research method is dictated by the research question, and both quantitative and qualitative approaches require intellectual and methodological rigour. Alone, neither form of research provides the big canvas. For example, the clinical benefits and hazards of planned caesarean section in the absence of clear clinical indication (currently a contentious issue) might be determined by quantitative randomised trials, allowing that ethical and feasibility considerations were appropriate. Qualitative research, on the other hand, could be used to analyse some of the issues influencing women who request Caesarean operations. These issues are complex and include their own personal safety, the perceived safety of their babies, the mothers' wishes and understandings, cultural influences, their need for personal control, and their willingness to delegate decision making to others.

Both of us have had the good fortune to work in a maternity unit where the research (and clinical) contributions of obstetricians and midwives are equally valued, but there are those within the maternity services who see quantitative research as 'hard' and doctor-driven, while they envisage qualitative research as 'soft' and midwife-dominated. Those are myths that this excellent book seeks to dispel. It is timely, and informs clinicians and researchers about the rationale for, and the tools of, qualitative research methods. We believe that this book will help to break down barriers, where they exist, between obstetricians and midwives on concepts of what makes for good research in maternity care.

Dame Lorna Muirhead, Immediate Past-President, Royal College of Midwives
Professor Jim Neilson, Professor of Obstetrics and Gynaecology,
University of Liverpool
Liverpool, August 2004

Introduction

Having been heavily criticised in the seventies for lack of 'evidence base', our speciality has made great strides in embracing the concept of evidence-based clinical practice. One can, therefore, appreciate why most of us constantly bombarded with clear hypotheses, thousands of participants and objective, measurable outcomes may find it difficult to acknowledge the relevance of studies containing a broad research focus, half a dozen participants and findings which are not, and were never intended to be, generalisable. Yet with the growing desire to explore quality of care, as opposed to just quantity, this methodological approach has now been recognised as an integral method of inquiry in maternity care. In fact, the conception of this book followed repeated requests for guidance from midwives and doctors wishing to conduct a piece of qualitative research in a rigorous way and not being able to find a suitable textbook.

We are heartened that the need for qualitative research is no longer forcefully challenged within practice settings. Clinicians do, however, continue to struggle with aspects of qualitative methodology, particularly in terms of theoretical underpinning, data collection and qualitative analysis and few have either the time or the inclination to wade through numerous textbooks that are often written in an unfamiliar language and leave them more confused than when they started!

The information in this book is not exhaustive, but aims to guide readers through all stages of the research process. The journey through the chapters will enlighten them to the purpose of qualitative research; inform them of considerations before they commence any research; outline the theoretical underpinning of the approach; highlight important ethical issues; discuss different methods of data collection; explore the process of analysis; suggest ways of assessing qualitative research; demonstrate how to integrate qualitative and quantitative research; and provide examples of how to explore the views of those who are hard to reach. Pivotal to this information are real research examples from maternity settings, which readers can relate to.

We hope that for those on the first rung of the qualitative research ladder, the information provided will allow their ideas to become a reality. Readers with qualitative research experience can use this book as a foundation from which they will develop more in-depth studies. But for all, the book should be a code-breaker, which has unravelled the complexities of an approach, which has previously mystified many.

Tina Lavender, Grace Edwards and Zarko Alfirevic
May 2004

Chapter 1

Why carry out qualitative research?

Carol Kingdon

The method consists in an attempt to build a bridge between the world of sense and the world of science.
Bertrand Russell, 1872–1970

Introduction

A knowledge of qualitative research is becoming increasingly important in healthcare systems that not only recognise the value of research into clinical outcomes, but also the benefits of understanding healthcare processes from the perspectives of those involved. Midwives and obstetricians seeking to adopt the methods of qualitative research in practice should appreciate that qualitative research has been a field of inquiry in its own right for nearly a century. Qualitative research has separate and distinguished histories in education, social work, communications, psychology, history, organisational studies, medical science, anthropology and sociology (Denzin and Lincoln, 2000).

Within maternity care obstetricians, midwives and service users have been asked to participate in qualitative research studies for many years. During the 1970s, a number of eminent British sociologists used qualitative interviews to explore the impact of social behaviours and circumstances on maternal and infant health in both the antenatal and postnatal periods (Oakley, 1979; Graham and Mckee, 1979). However, it is only within the last decade that a wider acceptance of the clinical relevance of qualitative research has emerged. As a consequence, scientific review processes for research ethics committees, funding bodies and editorial panels now require knowledge of both quantitative and qualitative research approaches.

In their paper published in the *British Journal of Obstetrics and Gynaecology* in 2001, Pope and Campbell (2001) acknowledged that qualitative research is no longer the sole preserve of social scientists. Clinicians from a wide-range of medical specialities should increasingly accept the methods of qualitative inquiry, such as in-depth interviews, focus groups and observation. Only six years earlier, the *British Medical Journal* ran a series of articles by the same authors introducing qualitative research to a largely uninitiated medical audience (Pope and Mays, 1995; Mays and Pope, 1995a, 1995b). The articles were commissioned, not as papers about qualitative research, but as a series on 'non-quantitative methods' (Pope and Mays, 1999). This is illustrative of the status and legitimacy accorded to only quantitative research in many medical specialties at the time.

In the past, the distinction between 'hard' and 'soft' data, and talk of a quantitative/qualitative divide has exacerbated the view that qualitative research is in some way inferior to quantitative (Rees, 2003). Where a quantitative/qualitative divide still exists it is a false polarisation, compounded by the promotion of hierarchies of evidence within which qualitative research has no place. Miller and Crabtree (2000: 612–3) state:

> *Evidence-based medicine is the new wonder child in clinical care and in clinical research. The proliferation of clinical practice guidelines is one result of these initiatives. Another result is the relative reduced value of qualitative studies. But evidence-based medicine actually offers qualitative clinical investigators multiple opportunities — there is so much missing evidence!*

Evidence from qualitative research alone is not the only way clinical researchers can 'discover' all this missing evidence. The findings of qualitative and quantitative research undertaken either concurrently or consecutively can compliment each other to aid understanding of the bigger picture. Undertaken alongside quantitative research, qualitative research may contribute to the evidence-based healthcare agenda by enhancing understanding of why interventions work; improving the accuracy and relevance of quantitative studies; identifying appropriate variables to be studied in quantitative research; offering explanations for unexpected results from quantitative work; and by generating hypotheses to be tested using quantitative methods (Black, 1994).

There are also important ways 'in which qualitative research can contribute to the pursuit of evidence based healthcare that are independent of the contribution of other methodologies' (Popay and Williams, 1998: 34). Popay and Williams (1998) discuss important examples of qualitative research that have explored 'taken for granted' practices in health care. They cite the work of Goffman (1961) as a particularly dramatic illustration of how qualitative research can show how healthcare institutions affect the behaviour of people that live and work within them. Goffman's observations of a single ward contributed to a paradigm shift in mental healthcare policy that has resulted in more humane, appropriate, effective and efficient care provision. Popay and Williams (1998) also discuss the value of 'stand-alone' qualitative research in offering a 'difference model' to understand lay/clinical behaviour, patient's perceptions of quality/appropriateness of care, organizational culture, change management and the evaluation of complex policy initiatives.

This chapter highlights the relevance of qualitative traditions to the study of everyday maternity care processes, the appropriateness of methods of qualitative inquiry to particular research questions, and the increasing value of qualitative research for maternity care policy makers. The intention is to lay the foundations for the book as a whole by defining the place for using (or not using) the methods of qualitative inquiry for the benefit of future evidence-based care. The use of examples from contemporary research investigating rising Caesarean section rates is intended to both illustrate key points and to establish the place of qualitative research in the study of this global phenomenon. A variety of exemplar qualitative studies investigating the medicalisation of birth, and interaction and communication in the intrapartum period are also cited to demonstrate how qualitative research can influence maternity care practice at individual, organisational and policy levels.

The chapter is divided into six key sections:

- what is qualitative research
- qualitative research to understand everyday processes
- qualitative research and healthcare policy
- the impact of qualitative research on practice
- qualitative research to complement randomised controlled trial methodology

- qualitative research and consumer involvement.

The first section discusses the defining characteristics of qualitative research and why a single homogeneous definition of 'qualitative research' remains so elusive.

What is qualitative research?

Murphy *et al* (1998) introduce qualitative research as a process that involves the collection, analysis and interpretation of data that are not easily reduced to numbers. Langford (2001) provides an equally succinct definition, describing qualitative research as an objective process used to examine subjective human experiences by using non-statistical methods of analysis. However, defining qualitative research as the antithesis to quantitative is helpful only at a very basic level. Because as acknowledged by Pope and Campbell (2001: 233) when posing exactly the same question: 'What is qualitative research? The answer varies depending on whom you ask.'

Sociologists working within social action theory, symbolic interactionism, phenomenology and ethnomethodology have traditionally used the methods of qualitative research (semi-structured interviews or participant observation) to acquire data rich in depth and meaning about individuals and social groups. Anthropology is a separate discipline to sociology, with anthropologists characteristically using ethnography in their fieldwork. Ethnography has evolved as 'multi-method' qualitative research that usually includes observation, participation, archival analysis and interviewing, thus combining the assets and weakness of each method (Reinharz, 1992). Fiona Dykes discusses research paradigms and the methodologies of the respective disciplines in more detail in the next chapter. The key point for this chapter is to recognise that 'qualitative research' has separate and distinguished histories within many social science disciplines. Those planning to undertake qualitative studies would benefit from understanding the wide choice of theoretical traditions, methodological approaches and methods of collecting data available to them.

Across the many disciplines engaged in qualitative research in the past or present, there is no single all encompassing homogeneous definition of 'qualitative research', so I have selected the following two extracts from the first and second editions of Denzin and Lincoln's edited collection the *Handbook of Qualitative Research* (1994; 2000) for the purpose of this chapter. The quotes emphasise many of what I believe to be the defining characteristics of qualitative research:

> *The word qualitative implies an emphasis on the qualities of entities and on processes and meanings that are not experimentally examined or measured (if measured at all) in terms of quantity, amount, intensity, or frequency. Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry.*
>
> Denzin and Lincoln, 2000: 8

> *Qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials — case study, personal experience, introspective, life story, interview, observational, historical, interactional, and visual texts-that describe routine and problematic moments and meaning in individuals' lives.*
>
> (Denzin and Lincoln 1994:2).

In the context of my own work investigating women's views of different ways of giving birth in the light of suggestions of the need for a randomised controlled trial of planned Caesarean section versus planned vaginal birth; qualitative research offers an approach to studying rising Caesarean section rates grounded in the complex interactions between expectant parents, well-intentioned midwives and obstetricians, organisational protocols, cultural norms and the influence of the media, family and friends. The extract below is from a transcript of an interview conducted postnatally with a twenty-eight-year-old woman who had an elective Caesarean section after her baby was diagnosed in the breech position. The extract illustrates the complex reality for this woman in a society where intervention in the physiological processes of birth is perceived by many to have improved on nature, and Caesarean section is no longer reserved for acute obstetric emergencies. Statistics highlighting the global trend towards rising Caesarean section rates tell us about the increasing frequency of the operation, but cannot provide all of the information as to why. The fact that qualitative research is grounded in every day social and cultural interactions is the single most distinguishing characteristic and its greatest strength.

Women's views of different ways of giving birth

This is an extract from a postnatal interview transcript with a twenty-eight-year-old woman whose first baby was delivered by elective Caesarean section during 2002. The interview was conducted as part of my current study exploring a cohort of women's views of different ways of giving birth in both the antenatal and postnatal period.

> Carol: Can you tell me how you feel about your childbirth experience?
> Helen: Well I think, think it was excellent. It erm... well it was strange really because I came [to the hospital]. I think when we first spoke [first antenatal interview] I really wanted to look at the idea of having a Caesarean. I mean it scared me but... erm. I've heard so many older women talk about having, you know giving birth, losing their sort of tightness underneath, and erm, becoming incontinent. You even see adverts on the TV with people who've got, pads for women who leak, erm I don't want to have that, I just don't want it.
>
> It was about the time Posh Spice[1] and all that were having Caesareans, too posh to push. Everything was negative, negative Caesarean, you know, major operation. Even in all the, I had my head in a pregnancy magazine every minute

1. 'Post Spice' Victoria Beckham was one of several high profile celebrities to receive widespread media attention in the UK during 2001 after the birth of their first child by elective Caesaran section

of the day and it was all women who'd had Caesareans, stomach was ruined after it, couldn't push the pram, couldn't breast feed, couldn't bond because they hadn't had a proper natural delivery. I used to think oh my goodness, this is a nightmare. You know it was like, as if you haven't gone through a proper twenty hours of hell, you haven't had like, it's like you haven't given, done what's right as a woman. I think that's stupid really.

Anyway at the time I remember thinking, oh no I'll go for a natural delivery, and it's weird. You know a lot of the reasons for wanting a section as well. My sister's son, I don't know if you remember me telling you? My sister's son is autistic, has learning difficulties and he got into a lot of distress during my sister's labour. My mam, put that down to a bad labour and that's always been in my mind...

But, anyway, it turns that when she turned breech, when it came to about three, four weeks before she was due, the midwife said I don't think you're baby's in the right position here. So they sent me to the clinic, I remember coming back from the midwife, lying in bed and Peter [husband] come in and I was crying. It was a nightmare, this isn't what I wanted I'd finally got my head round having a natural delivery and then when she was breech. They said they'd try and turn the baby, but I didn't want that, we agreed that was how it was meant to be.

Qualitative research to understand everyday processes

One of the most demonstrative examples of the value of qualitative research's *a priori* approach grounded in philosophical assumptions of interpretive and naturalistic enquiry in a contemporary maternity care setting is a qualitative study by Harris and Greene (2002a). The aim of Harris and Greene's (2002a) work was to investigate communication and interaction between midwives, doctors and parents within a single delivery room in Plymouth, UK. The care of twenty women was observed using a ceiling mounted unobtrusive audio-video recorder.

The research findings have been presented at a number of national conferences and study days in the UK (Harris and Greene, 2002a; Harris and Greene, 2002b). From over 111 hours of recording of the first stage and twelve hours recording of the second stage of labour, short video clips of the raw qualitative data frequently have a strong visual impact on audiences presented with the 'reality' of care in units where one-to-one midwifery care equates to midwives spending only 9% of their time supporting women during the first stage of labour.

Harris and Greene's (2002a) study is illustrative of the nature and value of qualitative research in a number of different ways. While results based on a sample of only twenty women may not be generalisable in a quantitative sense, they are transferable to other settings. The findings have a strong resonance with the everyday experiences of many professionals that suggest women accessing hospital care frequently feel unsupported in labour. The Cochrane Review of labour support has shown it to be the only known effective intrapartum intervention to reduce Caesarean section rates (Hodnett, 1999). In the UK, where the national Caesarean section rate continues to increase, Harris and Greene's (2002a) findings are clearly relevant.

Harris and Greene's (2002a) data are rich in the experiences of individuals

that could not have been accessed in such depth, in any way other than by using qualitative methods. Harris and Greene's research highlights not only the relevance, but also the importance of qualitative research in the study of everyday processes to aid understanding of what is good about current practice and what is not.

Another completed piece of qualitative research by Murphy *et al* (2003) is also illustrative of how an interpretive approach can highlight where maternity service users needs are not currently being met. Figures from the National Sentinel Caesarean Section Audit (Thomas and Paranjothy, 2001) suggest a third of women in British maternity units undergo operative delivery. Murphy *et al* (2003) conducted interviews with a purposive sample of twenty-seven women who had undergone operative delivery in the second stage of labour between January 2000 and January 2002. The research sought to obtain the views of women on the impact of operative delivery in the second stage of labour, to understand women's experience of delivery and how they made sense of what had happened to them. The study found that women reported deficiencies in antenatal preparation, unrealistic birth plans, a limited understanding of the indication for delivery, and insufficient opportunity for detailed personal review, with operative delivery having a noticeable impact on women's views about future pregnancies and preferred mode of future delivery. Murphy *et al* (2003: 1133) concluded:

> *Women consider postnatal debriefing and medical review important deficiencies in current care. Those who experienced operative delivery in the second stage of labour would welcome the opportunity to have later review of their intrapartum care, physical recovery, and management of future pregnancies.*

Harris and Greene (2002a) and Murphy *et al* (2003) have not only used qualitative research to investigate systematically previously missing evidence of women's experiences of maternity care but, in doing so, have also identified inadequacies in the current delivery of that care.

Qualitative research and healthcare policy

In 1998, the UK's government launched the concept of 'clinical governance' and with it a commitment to improving the quality of health care, in terms of both outcome and the experiences of those receiving care (Department of Health [DoH], 1998). Clinical governance has been defined as a policy, which 'aims to integrate all the activities that impact on patient care into one strategy. This involves improving the quality of information, promoting collaboration, team working and partnerships, as well as reducing variations in practice, and implementing evidence-based practice. Clinical governance is an umbrella term for everything that helps to maintain and improve high standards of patient care' (Currie, Morrell and Scrievener, 2003).

Midwives were asking research questions about the quality of information given to women in labour, a decade before the concept of clinical governance was introduced. Kirkham (1991: 118) in her seminal work exploring midwives information-giving during labour, combined the qualitative methods of observation and interviews to develop an 'analysis "grounded" in her data — data that was also the women's

experience'. Kirkham discusses how her choice of qualitative methods meant her, 'viewpoint was widened by childbearing women who, during the course of labour and subsequent interview, showed me the importance to them of things I might otherwise have overlooked. Their observations, values and concepts gave me insights that I would not have had as an ordinary working midwife' (Kirkham, 1991: 118).

In recent years, the emerging clinical governance agenda has had a positive impact on the status of qualitative research as there has been an increasing recognition that its methods of inquiry are often the only way to understand both health processes and their influence on health outcomes from the perspectives of those receiving care. Qualitative research enables researchers to ask questions such as, 'what aspects of maternity care are important to women, how does what is important to them vary depending on their circumstances, and why?' Rather than, 'how many women are there?' A key strength of the inductive process used in qualitative research is generalisations are produced from the empirical process, using participants' own categories and concepts, rather than imposing the researchers predetermined categories to test a hypothesis.

Qualitative work undertaken by Weaver (2000: 488) has illustrated the importance of midwives and obstetricians acknowledging 'some of the shared cultural and social understandings of childbearing women: the explanations available to them when they try to make sense of their experiences and the sort of knowledge that is drawn upon when they talk to each other about birth.' Because it is around such talk that expectation and fear can be built, and it is in such talk women frame their experiences of what constitutes good and bad quality of care.

Drawing on data from forty-seven interviews with postnatal women which forms part of a wider study investigating choice and decision making in Caesarean section, Weaver (2000) discusses how women talked about vaginal birth as an ideal; yet positive statements about vaginal birth were often followed by a 'but', with the notion of vaginal birth as desirable held in tension with the notion of vaginal birth as difficult or even hazardous. Women talked about images of vaginal birth likely to end in emergency Caesarean section as illustrated in the verbatim quotes below:

> I thought that I would probably have another section. And I guess the main reason for that was I felt that I'd really lost confidence from going through what I'd been through before. And I thought I don't want to go through that again and find myself in the same situation where I end up having another [emergency] section. And I thought the only way I really would have gone through a natural birth is if somebody had been able to say look, you will be able to deliver this baby naturally (pp. 489–490).
>
> I suppose I was influenced by the number of people I know that have had emergency Caesarean. I think there's about four people that I know that have had them within the last year or so. That makes a heck of a difference, 'cos that makes you think, my goodness is this ever going to be possible? Do people actually give birth naturally?

The quotes also demonstrate some of the many ways in which the women justified requesting an elective Caesarean section. Weaver (2000) is cautious about making recommendations from the interview data alone, but feels that her work does highlight

areas where changes need to be made. Her study suggests the need to promote positive images of vaginal birth in the management of pregnancy, and for more transparency about the risks associated with Caesarean section. As mentioned earlier in the chapter, qualitative research may not be 'generalisable' in a quantitative sense, but it is transferable and findings that resonate with the experiences of others have the potential to change practice.

The impact of qualitative research on practice

Pope and Campbell (2001: 235) assert 'the best qualitative work — research that is systematic and rigorous — moves beyond common sense, is more than "just anecdote" and has the power to transform clinical practices in positive ways.' In a similar way to that whereby Goffman's work contributed to a paradigm shift in mental health policy, a continuum of qualitative research investigating women's everyday 'taken for granted' experiences of maternity care has been influential in contributing to an international maternity care agenda that now advocates informed choice and woman-centred care.

Collectively the works of Shelia Kitzinger (1962, 1978, 1982) and Ann Oakley (1979, 1980) in the 1970s and early 1980s, Mavis Kirkham's work in the late 1980s, and more recently Robbie Davis-Floyd (1994) amongst others, have influenced both individual women during their pregnancies, and groups of men and women as midwives, obstetricians and healthcare policy makers. It is a triumph of feminist qualitative research that so-called 'soft' outcomes, such as communication and understanding, bonding and attachment, and psychosocial support are all now firmly on the policy agenda in both the UK and the USA.

Individual qualitative research studies can also have local impact, which with appropriate dissemination can lead to widespread change. For example, where two fetuses are identified by ultrasound in early pregnancy, but only one fetus is subsequently seen, the 'condition' has been described as a 'vanished twin'. It has been suggested that of all twin pregnancies identified at an early ultrasound scan, thirty percent will become a 'vanished twin', with the mothers traditionally receiving the same antenatal and postnatal care as if they had only ever experienced a singleton pregnancy. Briscoe and Street's (2003) qualitative research with women who had experienced a 'vanished twin' found that women would like acknowledgement of the pregnancy as having started as two babies and ending with only one.

> *The women felt that their pregnancy loss was dismissed by caregivers and that information, advice and reassurance relating to the event were lacking.*
>
> Briscoe and Street, 2003: 52

In response to the study findings, women are now provided with an information sheet to read and take away with them, which provides answers to the questions raised by women during the course of the research.

Many of the examples of qualitative research cited in this chapter highlight how frequently women view their experiences of care negatively. This is not necessarily associated with poor outcomes, but because they did not receive either sufficient information to prepare them for the physical or psychological impact of childbirth,

or adequate information to enable them to make informed decisions and actively participate in their care.

O'Cathain *et al* (2002) undertook a randomised controlled trial (RCT) in thirteen maternity units in Wales in order to assess the effect of leaflets on promoting informed choice in women using maternity services. To understand the social context in which the evidence-based leaflets were used; qualitative research was undertaken alongside, but independent from, the trial (Stapleton, Kirkham and Thomas, 2002). The qualitative research found that the environment had a crucial influence on the way in which the leaflets were disseminated, thus affecting informed choice. Stapleton, Kirkham and Thomas (2002: 422) concluded, 'the culture into which the leaflets were introduced supported existing normative patterns of care and this ensured informed compliance rather than informed choice'. Their work illustrates how undertaking qualitative research at the same time as quantitative research is a useful way to identify potential barriers to the implementation of RCT findings by clinicians and maternity service users.

Qualitative research to complement randomised controlled trial methodology

In the social sciences, undertaking qualitative and quantitative research simultaneously to provide a multi-layered, more valid picture is known as triangulation: 'multiple methods or perspectives may be used for the collection and interpretation of data about a phenomenon, in order to obtain an accurate representation of reality' (Polit and Hunger 1999). The advantages of such an approach have been highlighted recently in Lavender and Chapple's (2003) work commissioned by the Department of Health's Neonatal Taskforce to investigate models of maternity care. The data from the quantitative questionnaire element of the study indicated that the majority of women wanted immediate access to doctors, a Special Care Baby Unit in the place where they give birth, and twenty-four-hour access to epidurals. However, the qualitative data found that that women were clearly unaware that midwives have the ability to work autonomously, identify risk and deal with obstetric emergencies. The triangulation of data suggested women's current beliefs might be misguided by their lack of knowledge about the midwife's role. Issues surrounding the combining quantitative and qualitative data are discussed in detail in *Chapter 7*, so I will consider only briefly the advantages of undertaking qualitative research to complement quantitative data specifically from randomised controlled trials.

Oakley (2000) has described the randomised controlled trial (RCT) as medicines prime way of knowing. The RCT evolved as an alternative to the uncontrolled experimentation of 'normal' practice, and as offering answers to questions about effectiveness and safety, which individual doctors cannot answer from the experience of individual cases (Oakley, 2000). The synthesis of evidence from RCTs using meta-analysis within Cochrane Systematic Reviews began in the field of pregnancy and childbirth. Consequently, the focus on evidence-based practice in obstetrics is well developed (Audit Commission, 1997). It is unfortunate that an unintended consequence of evidence-based practice has been a false polarisation of quantitative and qualitative research, compounded by increasing popularity of a hierarchy of evidence considered worthy of influencing a change in clinical practice.

However, obstetrics and midwifery is more than the application of scientific rules that dictate practice only if based on evidence from RCTs.

Caring for women during pregnancy and birth has a profoundly human element where clinical judgement is also informed by social context. It is widely acknowledged that RCTs are the best source of evidence of the effectiveness of clinical interventions (Popay and Williams, 1998; Miller and Crabtree, 2000) but evidence of effectiveness alone does not necessarily mean that an intervention will be widely implemented:

Miller and Crabtree (2000: 613) have argued:

> *Read any RCT report, the only voice you hear is the cold sound of intervention and the faint echoes of the investigator's biases. The cacophonous music of patients, clinicians, insurance companies, lawyers, government regulatory bodies, consumer interest groups, community agencies, office staff, corporate interests and family turmoil is mute. There has also been little research into the clinical expertise side of the EBM equation and the associated areas of relationship dynamics, communication, and patient preference: there is much to be learnt about how patients and clinicians actually implement* '*best evidence*'.

Qualitative research can investigate practitioners' and patients' attitudes, beliefs and preferences, and the whole question of how evidence is turned into practice (Green and Britten, 1998: 1230). For example, the UK's Royal College of Obstetricians and Gynaecologists (RCOG) *Clinical Green Top Guidelines on the Management of Breech Presentation* recommend all women with uncomplicated breech presentation at term (thirty-seven to forty-two weeks) should be offered external cephalic version (ECV) (Johanson, 2001: 1). This guideline is based on the results of six RCTs that have found a significant reduction in the risk of Caesarean section in women where there is an intention to undertake ECV without any increased risk to the baby.

There are few published studies evaluating women's views of the procedure, and there is clearly a need for more qualitative research to understand the appropriateness of ECV from the perspective of pregnant women. While ECV is not the focus of my work, investigating women's views of different ways of giving birth, it has been an issue for the women who have participated in the study and their baby has been in the breech position at term. The procedure was clearly not acceptable to 'Helen' quoted earlier (*p. 4*) but we do not know whether this is because of the way information about ECV was provided to her, or whether she viewed elective Caesarean section as less 'risky' than ECV. A collaborative study involving both obstetric and midwifery colleagues at Liverpool Women's Hospital, UK is currently using qualitative interviews to explore why women decline the evidence-based intervention of ECV (Walkinshaw, Blayney and Briscoe, 2004).

Conducting an RCT is a fruitless exercise if the results are not acceptable to women and/or clinicians. Bewley and Cockburn (2002) make reference to a powerful debate taking place in the medical and lay press regarding elective Caesarean section for 'maternal request' even in normal uncomplicated pregnancies. However, as professional concerns promoting physiological birth at one end of the spectrum and Caesarean section at the other are increasingly taking centre stage, there is a danger of losing site of the fundamentally important question of how the individual women