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Information Control and the Exercise of Power in the Obstetrical Encounter

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Abstract

Interactions between doctor and patient involve participants with unequal power and possibly different interests. While a number of studies have focused upon the doctor/patient relationship, few have examined the utility of the concept of power and its capacity to help us understand the outcome of these interactions. The information sought by pregnant women from their obstetricians is used to provide a case study of one conceptualization and test of the utility of the concept of power. Pregnant women and their obstetricians are found to have different perceptions of the information that should be exchanged during their interactions. Women generally fail to obtain the information they want. Lower social class patients desire more and obtain less information than their higher status counterparts.

INTRODUCTION

The communication of information by professionals to patients has been one of the major sources of dissatisfaction in health care delivery. Repeated studies have confirmed that many patients receive little information from their doctors [1, 2]. Doctor/patient interaction involves two participants, and an adequate understanding of the interaction process must encompass the patient's apparent unwillingness to ask questions [3,4] as well as the clinicians' reluctance to provide it.

One general formulation of the professional-client interaction process adopts a conflicting subcultures framework and explains the clients' lack of success in obtaining information by referring to the clinicians' differing interests and greater power [5]. Others have argued that clinicians withhold information 'to maintain patterns of dominance and subordination' [6]. While previous studies have been useful in pointing to the power differential between client and professional as one important cause of the withholding of information, these studies have not been carried out in a sufficient variety of settings; they have not included a longitudinal component (a client may not receive information in one encounter but may be informed subsequently); and they have failed to specify why some patients obtain information and others do not.

This study examines the encounters between pregnant women and their obstetricians. It is concerned with the extent to which women are able to obtain, as part of their antenatal care, the information they would like to have about the baby, labour, appropriate health behaviour and other specific topics.

BACKGROUND: CHANGES IN ANTENATAL CARE

The medical care for the pregnant woman, in common with many other 'conditions', has been subjected to considerable technological innovation. Consequently, the social environment associated with this care has also been transformed. Traditional relationships and sources of information exchange have been curtailed as reproduction, labour and childbirth have become part of a new medical science. The emerging conflict between the advocates of the new natural childbirth movement and their medical critics provides a background for this study.

The routine use of regular antenatal care provided by an obstetrician (not a general practitioner or nurse) is illustrative of the new orientation to obstetrical care. Procedures such

as amniocentesis, ultrasound and electronic fetal monitoring have further contributed to the increased perceived importance of regular antenatal care in the care of pregnant women. Obstetricians have used the availability of the newer technologies as an argument for absolute and unquestioning compliance by their patients. Beazley [7] writing in the *American Journal of Obstetrics and Gynaecology* argues that:

> 'The active management of labour necessitates that obstetricians take over, not just a single aspect of delivery but responsibility for the whole process of parturition. Our control of the situation must be complete' [8].

Clearly, the control of information the women might wish to receive remains, in the medical view, at the discretion of the obstetrician.

The dominant position of the medical profession in obstetrical encounters has led to a reaction by some women who are concerned about their lack of participation in the childbirth experience. These women challenge the medical management of childbirth [9-11]. Others advocate health collectivities. In these settings literature is made available to women to enable them to make informed decisions about their future health care [12]. Women are advised to reject the passive role and take charge of labour and childbirth themselves [13].

The routine and unproblematic nature of most antenatal care coupled with the differing perceptions by obstetricians and at least some of their patients provides the ingredients for possible conflict and therefore an ideal environment in which to examine the exercise of power. Yet the normative expectations of both clinician and patient limit the likelihood of overt conflict. It is essential then to have a clearer conception of how one might measure the conflict-free exercise of power in obstetrical encounters.

Both participants in the encounter are likely to take to it expectations about appropriate information exchange. In a situation where the desires of the participants are, as we have observed, opposed, one would expect that the more powerful participants' preconceptions about the encounter will prevail.

POWER IN OBSTETRICAL ENCOUNTERS

Any discussion of power must begin with Weber and his view that power involves the capacity of a person (or group) to attain what they desire even against the resistance of others [14]. While there have been numerous discussions of the concept of power and its measurement [15], Lukes [16] has provided the most interesting extension of the concept. Lukes refers to the one, two and three dimensional views of power. The one dimensional view argues that power may be measured by studying the decision making process and recording whose decisions prevail. The two dimensional view suggests that the study of overt conflict may not reveal all situations in which power has been exercised. Thus some persons may be so powerful that they prevent others concerns from reaching the decision making agenda. Decision making may be restricted to safe issues. Lukes argues that an absence of grievances or conflict can indicate, not a genuine consensus, but the existence of a false or manipulated consensus. The three dimensional view implies that the subtler and arguably supreme form of the exercise of power involves influencing another's preferences so that conflict, even covert, does not arise. Power, in this latter instance, is achieved by influencing, shaping or determining others' very wants. One may know if power has been exercised by observing that a person or group has acted against their own interests, even though they may express satisfaction and contentment with the outcome. This approach to measuring power points to situations where there is no apparent conflict but where one supposes there should be.

It is this three dimensional view of power which may be relevant to understanding the nature and consequences of the obstetrical encounter. According to this third view, one could examine obstetrical encounters to determine whether women may be acting against their own

interests. Any such analysis must consider the difficulty of establishing whether a particular outcome is in someone's interest.

While interests might be interpreted in a number of ways, we suggest the following definition for the purposes of this study. An interest involves both a desire to obtain a service (or good) allied to a reasonable expectation that this service (or good) will be to ones benefit. In this study the service which clients might desire is information about the health of their baby, about labour, appropriate health behaviour and some other topics (e.g. books to read, sexual relations during pregnancy).

The obstetrical encounter involves two unequal participants. An obstetrician has 'legitimate authority' and what Freidson, in referring to doctors in general, has described as 'unrivalled power to control his own practice and the affairs that impinge upon it' [17].

SAMPLING AND METHODS

The study began with a period of observation and semi-structured interviews in a large public hospital which accounts for about half the births in a city of approx. 1,000,000 persons. This exploratory period produced the hypothesis that many women had numerous concerns about their pregnancy and that these concerns were not raised during the medical care they received.

Subsequently, a sample of 110 women having their first baby were surveyed. They comprised 54 public hospital patients (obtaining 'free' medical care) and 56 private patients. The sample was selected by choosing a random starting date and taking all consecutive women less than 16 weeks pregnant and having their first baby as a public patient of a large hospital or who chose to use private obstetricians at the same hospital. Private obstetricians participating in the study were selected by their university colleagues partly because they were active in academic activities. Thus these obstetricians are not representative of obstetricians but are likely to be more interested in the types of concerns addressed in this study. In some instances the same obstetrician was involved in treating both public and private patients. The study was presented as a survey of respondents needs, particularly for information about their pregnancy. There were no refusals.

Women were given a first questionnaire at their initial obstetrical visit, and a second questionnaire at about 36 weeks. The analysis is restricted to the 96 women (87% of original sample) who answered both questionnaires.

The final sample of 96 women was divided into three social class groups (Table 1) by using a composite score based on the woman's education, her family's income and her husband's occupation. While lower class patients almost exclusively chose public care, about two-thirds of the middle and upper class patients chose private obstetricians.

The first questionnaire contained a list of topics. Thereafter the Pregnancy Information List (PIL), which were derived from an extensive period of pre-testing. Clients were asked to indicate whether they would like to obtain information from their doctors on each of the topics. They could respond by indicating they wanted information a lot, a little or not at all.

Table 1. Type of care by social class

	Social class		
	Lower	Middle	Upper
	n=26	*n* =50	*n* =20
Public (%)	58.5	38.0	35.0
Private (%)	11.5	62.0	65.0
	100.0	100.0	100.0

The prestesting indicated that some common and recurring concerns are apparent. Cronbach's

Alpha coefficient was used to determine the items which belonged to a particular subscale. This first questionnaire also contained some demographic and attitudinal items.

The second questionnaire repeated the list of items from the PIL, but this time with a request that clients should indicate whether the topic was discussed with their obstetrician (no/yes) and secondly whether further discussion on each topic was desired (no/yes).

A third questionnaire was given to the obstetricians treating the sample of women. Obstetricians were provided with the same list of items (PIL) and asked to indicate whether they felt that their women patients wanted to discuss these topics with them. This last questionnaire identified doctors' expectations of appropriate information exchange in the obstetrical encounter.

Table 2. Which of the following areas would you like to discuss with your doctor early in pregnancy?

	(1) A lot (%)	(2) A little (%)	(3) Not at all (%)
About the baby*			
Deformities (*n* = 89)	38	46	16
Foetal development (*n* = 93)	47	41	12
Health of the baby (*n* = 93)	68	31	2
About labour†			
When to come to hospital (*n* = 93)	47	46	6
Labour (*n* = 93)	60	35	4
Sedation in labour (*n* = 93)	57	37	6
Forceps delivery (*n* = 92)	47	46	8
Caesarean section (*n* = 92)	46	45	10
Breathing techniques (*n* = 93)	59	30	11
Father's involvement in labour (*n* = 93)	53	38	10
About health behaviour ++			
Nutrition (*n* = 94)	53	40	6
Vitamins (*n* = 93)	45	44	11
Dangerous drugs (*n* = 91)	45	33	22
Medication (*n* = 90)	38	49	13
Alcohol consumption (*n* = 89)	13	30	56
Smoking (*n* = 89)	13	20	66
Miscellaneous §			
Childbirth education classes (*n* = 93)	35	45	19
Books to read (*n* = 89)	16	54	30
Sexual relations during pregnancy (*n* = 92)	24	59	17
Breastfeeding (*n* = 93)	47	43	10
Nipple preparation (*n* = 94)	43	48	10
Future contraception (*n* = 92)	45	35	21

Cronbach's Alphas for each of the subscales are: * 0.75; † 0.95: ++ 0.88; § 01.86.

The fact that women were presented with a list of items for discussion may suggest the possibility of some form of acquiescent bias. It could be argued that some respondents, given a list of items on any subject, might perceive this list as an invitation to tick every item. There are three responses to this suggestion. Firstly, most women were selective, in their choice of topics. Secondly, the issue is not whether the information is 'really' wanted but rather that if women report a desire to be better informed then one may appropriately determine whether

they have been successful in obtaining this information. Finally, one would need to postulate some form of systematic bias which would negate the results. In our pretesting and subsequent analysis of data we did not perceive the existence of this type of bias. These arguments do not, of course, deny the possibility that some form of as yet unknown bias may compound our results.

FINDINGS

The 22 items in the PIL appear in Table 2. The items have been aggregated, for further analysis, into four subscales. Each of these subscales contains a set of items which appear to measure the same underlying construct (Cronbach's Alpha ranges from 0.75 to 0.95) suggesting there exists a generalised desire for knowledge on the part of some respondents. The magnitude of their desire is impressive. Thus approx. 60% of women want a lot of information about the health of the baby, labour and breathing techniques and 90% of women would like to obtain information from their obstetrician for 10 of the 22 topics.

Table 3. In your experience. which of the following do women want to discuss with you? Indicate proportion of women wanting to discuss this concern

	Percentage of doctors who correctly anticipate that over half their patients want to discuss these topics (*n*=14)
About the baby	
Deformities	21
Foetal development	21
Health of the baby	85
About labour	
When to come to hospital	71
Labour	57
Sedation in labour	43
Forceps delivery	29
Caesarean section	14
Breathing techniques in labour	7
Father's involvement in labour	21
About health behaviour	
Nutrition	14
Vitamins	7
Dangerous drugs	21
Medication	43
Miscellaneous	
Childbirth education classes	21
Books to read	14
Sexual relations during pregnancy	29
Breastfeeding	64
Nipple preparation	21
Future contraception	50

*Two items, alcohol consumption and smoking, have been excluded from this table.

Obstetricians generally underestimate the desire for information reported by their patients (see Table 3). For example, only 21% of obstetricians believe a majority of women want to know about the possibility that their baby is deformed (84% of women want this information). Similarly, 14%, of obstetricians believe the majority of women would like to know about books to read (70% of women want this information.) Approximately 90% of women want to know more about a Caesarean section, breathing techniques and father's involvement in labour. This contrasts markedly with the percentage of obstetricians who correctly acknowledge this level of concern.

Interestingly, the client's desire for information is associated with the social class background of the client and the type of care (public or private) she has received (see Table 4). While 73% of lower class patients would like 'a lot more' information about the baby, only 47% of upper class patients report the same desire for knowledge. A similar pattern is evident for the other subscales and the public and private patients. The lower the class of the patient, the greater is likely to be her desire for information on a wide range of topics.

In order to determine whether the patients were successful in obtaining information, data from the first and second questionnaires were combined to create some derived variables. Respondents were given a score of 2 if they indicated they wanted a lot of discussion on a topic, but subsequently failed to discuss the topic with their obstetricians. A score of 1 was given to respondents who stated they wanted a little discussion but failed to have any. If a respondent stated she had discussed the topic with her obstetrician or if she had no desire to discuss a topic, a score of zero was allocated[1]. In this manner each respondent received four subscale scores based on the gap between what they wanted to know and the discussion that subsequently followed. For each sub-scale, the respondent received a score which represented her 'average' desire for information. Missing data have been eliminated from the calculations.

Table 5 indicates that between 30 and 40% of women report they discussed all or almost all the topics they wanted to, with their obstetricians. This does not, of course, imply that all these discussions were successful in providing the quantity of information sought. By contrast, 13-34% of women reported they did not discuss any (or almost any) of the topics with their obstetricians. Overall, the majority of women in our sample did not discuss the range of topics in which they previously specified concern, with their obstetricians.

In Table 6, the percentages represent the proportion of each social class group who had consistently failed to discuss almost all the topics they listed (the low power group). There appears to be a consistent and moderately strong association between power and social class or type of care. The lower the class of the respondent, the less likely the respondent is to obtain information she wants (the lower her power score).

Table 4. Respondents who, early in pregnancy, state they would like to discuss topics with the obstetricians by respondent's social class and type of care. (Percentage responding very positively for each scale)

Percentage who consistently state they want a lot or a little information from their doctors	Social class				Type of care		
	Lower	Middle	Upper	P	Public	Private	*P*
About the baby	73	65	47	*	66	61	NS
About labour	85	77	47	*	81	65	NS
About health behaviour	77	69	58	†	74	64	NS
On a range of other topics	81	68	63	NS	81	60	†

*$0.05 < P < 0.10$ Kendall's τ.

†$0.01 < P < 0.05$ Kendall's τ.

The gap between a respondent's desire for information and the extent to which the information is provided was derived by aggregating the remaining desire for information late in pregnancy (see Table 7). Towards the end of the pregnancy, public clients still want more information than private patients, regardless of the clients' social class. While the frequencies in Table 7 are low, the consistent pattern of results, coupled with some significant associations,

[1] It could be suggested that placing women who want no information in the same category as those who want information (and receive it) produces an impure category. If one accepts our conceptualization of power which emphasises the gap between what a respondent would like to know and what she is able to find out, then our approach to measuring the concept appears appropriate. Furthermore, it is relevant to note that there were few women who wanted no information. Thus the high power group consists of women who wanted information and obtained it.

points to the importance of the type of care received rather than the patient's social class background. Thus upper class patients who receive public care are likely, near the end of their pregnancy, to want much more information than upper class patients who receive private care. This implies that the system in which the patient finds herself is the major factor which determines whether she obtains the information she wants.

Table 5. Respondents who, early in pregnancy, state they would like to discuss topics with their obstetricians and the extent to which, by late pregnancy, discussion has taken place

Percentage of respondents who:	About the baby (n = 91) (%)*	About labour (n = 93) (%)	About health behaviour (n = 90) (%)	Other topics (n = 92) (%)
Have discussed all or almost all the topics they wanted (high power)†	40	30	40	35
Have discussed some of the topics they wanted (medium power)	41	36	47	39
Have discussed few or none of the topics they wanted (low power)††	20	34	13	26
Total	101	100	100	100

* Rounded to nearest whole percentage.

† Score 0 → 0.49

†† Score 1.05 → 2.00.

Table 6. Respondents who, early in pregnancy, state they would like to discuss topics with their obstetricians and the extent to which, by late pregnancy, discussion has taken place by respondent's social class and type of care

Percentage who, early in pregnancy, state they would like to discuss topics with their obstetricians and who by late pregnancy have discussed few or none of the topics they wanted (low power)	Social Class				Type of Care		
	Lower	Middle	Upper	P	Public	Private	P
About the baby	23	22	11	*	19	21	NS
About labour	46	31	26	†	40	28	*
About health behaviour	15	18	11	*	15	11	*
On a range of other topics	39	21	21	†	34	18	†

* $0.05 < P < 0.10$ Kendall's τ

† $0.01 < P < 0.05$ Kendall's τ.

If obstetricians fail to appreciate the degree to which information is sought then patients, it could be argued, should ask. In order to understand more about the circumstances surrounding the difficulty of asking the obstetrician questions, a nine-item attitude scale was created (see the Appendix). This scale had a Cronbach's Alpha of 0.899. The items contributing to the scale were aggregated and the sample divided into those persons who repeatedly stated they found it difficult to ask their obstetrician questions, those who sometimes asked questions and those who consistently reported that they found it easy to ask their obstetrician questions. Public patients (see Table 8) find it much more difficult to ask questions than do private patients. Interestingly, the social class of the patient is relatively

unimportant by contrast with the type of care received.

Table 7. Patients who, late in pregnancy, state they would still like information from their obstetricians by patient's type of care, controlling for social class

	Social class								
	Lower			Middle			Upper		
	Public	Private		Public	Private		Public	Private	
	Type of care			Type of care			Type of care		
Percentage who consistently state they want more information on almost (or) all topics	Public	Private	*P*	Public	Private	*P*	Public	Private	*P*
About the baby	52	0	†	26	23	NS	43	15	†
About labour	57	0	++	26	19	NS	29	8	*
About health behaviour	26	0	NS	32	l3	NS	43	8	*
On a range of other topics	52	0	*	37	19	NS	43	0	++

* $0.05 < P < 0.10$ Kendall's τ.

† $0.01 < P < 0.05$ Kendall's τ.

++ $0.001 < P < 0.01$ Kendall's τ.

DISCUSSION

There are four concerns which warrant further discussion. These are the patient's desire for information, the obstetrician's perception of the extent of this desire, the consequences of the obstetrician patient interaction in providing the desired information and the consideration of a model which could account for the above findings.

Obstetrical patients consistently report a desire for information on a range of topics. Surprisingly, the lower the woman's social class, the more likely she is to report that she would like to obtain information from her obstetrician. This appears to be because middle and upper class women report using a wider variety of sources of information (e.g. books, child-birth education classes) than do lower class women [18].

Obstetricians greatly underestimate the desire for information reported by their clients. Despite their greater desire for information from their obstetricians, public patients obtain less of the information they want, than do private patients. The knowledge gap between public and private patients appears to have grown during the pregnancy.

The observational component of this study suggests some possible explanations of the differences between the care provided to public and private patients. Public patients were required to follow a set and somewhat protracted routine in the hospital passing through a number of phases of care. Women seeking antenatal care began by having their history, weight and blood tests taken by nursing or technical staff. They reported to a desk for a number and urine bottle. After waiting to see the doctor, they changed in a room adjoining the examination room (while another examination was in progress). Finally they had an opportunity to discuss their problem with their obstetrician. Much of this discussion was limited by the presence of another patient who was undressed and awaiting examination within hearing distance and while the patient herself was in 'horizontal orbit' and unclothed.

Indeed it appears that patients in the public hospital are 'processed' through many stages and thus have few opportunities to establish a relationship with their health care providers. By contrast, private patients visit their obstetricians in private rooms. The patient's history and other details are almost invariably taken by the obstetrician and time may be provided before or after the examination for an airing of concerns, questions and problems. While the 'free' public hospital system appears to be organised for the convenience of staff and the 'efficient'

through-put of clients, obstetricians in the private setting make some effort to provide more than a technically excellent service. This does not imply that the quality of technical care private patients receive is better (or worse) than that obtained by public patients.

Table 8. Attitude to asking the doctor questions by type of care, controlling for social class

Attitude to asking the doctor questions about the pregnancy	Social class of patient					
	Lower*	Lower*	Middle†	Middle†	Upper++	Upper++
	Type of care	Type of care	Type of care	Type of care	Type of care	Type of care
	Public	Private	Public	Private	Public	Private
Generally finds it difficult to ask the doctor questions	35	0	42	10	29	8
Willing to ask doctor questions sometimes	61	33	47	52	37	46
Consistently finds it easy to ask doctor questions	4	67	11	39	14	46

*Kendall's $\tau_c = 0.30$; $0.01 < P < 0.05$.
†Kendall's $\tau_c = 0.43$; $0.001 < P < 0.01$.
++ Kendall's $\tau_c = 0.37$; $0.05 < P < 0.10$.

These different settings however do appear to influence the extent to which obstetricians discuss topics and, one supposes, provide information, to their patients. Private patients, regardless of their social class background, report much less desire to obtain information from their obstetricians by late in their pregnancy. Private patients, regardless of their social class background, are much more likely to find it easy to ask their obstetrician questions. In these circumstances, one could argue that an inability to 'pay' for medical care diminishes the respondent's power over the process of interaction during the obstetrical encounter. The two dimensional view of power would suggest that many issues of concern to women are not discussed because the obstetrician may manipulate the interaction so that these concerns do not reach the agenda.

While[2] the issue of client satisfaction was not specifically investigated in this study, repeated client interviews provided the impression that patients were generally satisfied with the care they received. Patients tended to take the view that if the information was not provided, the information may not be needed or that it should be obtained from some other source. If these impressions prove correct then, it could be argued, these women's perceptions of appropriate interaction have been changed by their experiences with their obstetricians. Such a manipulated consensus is consistent with the three dimensional view of power.

CONCLUSIONS

In general, most respondents fail to obtain all the information they would like to obtain from their obstetricians, even after many antenatal visits. Yet our observations point to an absence of conflict and the existence of a high level of satisfaction during the obstetrical encounter. While the obstetrical encounter contains the elements necessary for conflict (obstetricians and patients disagree about the appropriate content of their interaction), the situation appears to be remarkably conflict-free.

[2] This interpretation is based upon the period of observation and interviewing which occurred prior and during the actual survey of respondents. Repeated testing of measures of client satisfaction led to their elimination because these items did not discriminate between respondents. Some 90% of respondents consistently reported a high level of satisfaction with the care they had received.

In view of these findings, it is relevant to question the benefits which some patients derive from a 'free' health system. By not 'paying' for obstetrical care, many patients appear to lose their capacity to control the quality and quantity of interaction that occurs during the obstetrical encounter. Their 'second class' status is exemplified by their failure to obtain the information they desire.

Finally, while the obstetrician can be seen to have exercised power, the remarkable aspect of the process is the subtlety with which it proceeds. Patients leave the encounter essentially satisfied with the interaction and apparently unaware that their interests have been set aside.

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APPENDIX

Items in Attitude to Asking the Doctor Questions Scale

1 I find it hard to talk about my problems

2 I feel silly asking so many questions

3 I wish I could talk my problems over with the doctor

4 It worries me that I may be bothering him

5 Bringing up a question is too hard

6 I find it just too difficult to ask too many questions

7 There are many more questions I would like to ask the doctor

8 I would really like to discuss my pregnancy with the doctor

9 I seem to have a lot of unanswered questions

Cronbach's Alpha = 0.899.