CONSUMER CHOICE AND MIDWIFERY: A QUALITATIVE ANALYSIS

by

KELLY SHANNON MANLEY

(Under the Direction of Brenda Cude and Teresa Mauldin)

ABSTRACT

Childbirth presents a situation in which women have the potential to be active decision-makers in how they labor and deliver. However, unforeseen circumstances can affect the degree to which women have control in this healthcare environment. Thirty women who recently used midwives were interviewed to discover the environment in which they made their choices and the most influential factors in their decision-making process. The Theory of Planned Behavior, which accounts for decision-making in circumstances in which individuals may not have complete control over the ultimate outcome, seems to best capture this particular consumer healthcare decision. This information may be used to influence maternal healthcare policy in the United States.

INDEX WORDS: Midwifery, Consumer Choice, Consumer Information Search, Theory of Planned Behavior, Childbirth

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DEDICATION

For my parents, Tom and Pat Manley.

You convinced me to go to college and I never stopped!

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Most of all, I thank my parents, Tom and Pat Manley. I will never, ever, be as smart as you are. Thank you for supporting me in everything I do. You are better parents than I deserve.

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CHAPTER ONE

INTRODUCTION

Years ago a woman might see one family doctor for her healthcare needs over the course of her lifetime, seeing the same doctor for routine checkups, illnesses, and pregnancies. The kindly family doctor memorialized in Norman Rockwell paintings delivered a baby and took care of her until he retired. There was a sense of both relationship and intimacy, in that the doctor was familiar with his patient from her first breath, documenting her developmental progress, her childhood illnesses and traumas, and her emergence into adulthood. Doctors could follow their patients and feel a sense of satisfaction in helping them lead healthy lives as they watched them grow and have families of their own. Patients, having a sense of trust in their family doctor, had few, if any, decisions to make in such a simple environment.

In American society today, people are more mobile, requiring them to find new doctors to replace the ones they have left. Over time, the healthcare environment has become more complex, requiring more decisions on the part of consumers. The increase in the number of medical specialties and alternative medicine providers also has increased the number and the complexity of the options for consumers. A "family" doctor or general practitioner rarely provides all of the services an individual may need throughout the life course, requiring many people to make several choices for healthcare providers throughout their lifetimes. Often times, these decisions are constrained by limitations set by insurance coverage. In addition to whom they see for medical attention, individuals often are faced with choices in terms of their treatment

options, such as drugs, surgery, or alternative therapies, to name but a few. The relative ease with which people now may find health information (using, for example, the Internet), has increased their ability to participate in the decision-making process (Solovitch, 2001). On the other side of the market, healthcare providers also are beginning to treat patients as consumers, especially in terms of their marketing practices (Francese & Edmondson, 1986). Advertisements for prescription drugs, cable channels devoted to health issues, and advertisements for doctors, clinics, and hospitals are commonplace on television, in print, and even on the hoods of NASCAR racecars. One specialty in particular, Obstetrics, enthusiastically has embraced a consumer orientation in its marketing endeavors (Marshall, Javalgi, & Gombeski, 1995).

Despite these trends it is unclear whether people (patients) see themselves as consumers in healthcare settings. Do people in healthcare markets actually view what they are doing as a consumer transaction? Would people who would readily protest service with which they were dissatisfied in another market, such as a bad haircut or poor service at a restaurant, protest the care they receive in a healthcare setting? How do people go about making choices in healthcare markets? Do they see themselves as competent to process information as consumers in healthcare decisions?

It can be difficult to study consumer healthcare decision-making, given that many times when people find that they need to make a medical choice or decision, their time frame is quite limited. If a person is in the midst of a heart attack, for example, there is no time to research hospitals and doctors, and possibly very little, if any, time to become informed about possible immediate therapies beyond what the first doctor to see the patient offers. However, for other medical decisions patients have a longer time frame in which to make choices about their

treatment plans. They may have at least several viable and well-documented options. It is in these situations that it is easiest to study the decision-making process in healthcare settings.

One such situation is the expected birth of a child. For most women, the choice of a birth attendant is not a last-minute decision. Women with low-risk pregnancies have several options for their birthing attendants, from traditional medical doctors (obstetricians or general practitioners) to several kinds of midwives (such as certified nurse midwives, direct-entry midwives and lay midwives) and other birthing assistants (doulas). Midwives, though the most common form of birth attendant throughout history and around the world, largely were replaced in the United States during the early 1900's by medical doctors as the use of interventions such as anesthesia became more popular (Rothman, 1991). However, beginning in the 1970's, midwifery began to become more popular again, largely due to many women wanting to regain control over what they felt was a natural event that was being overmedicalized and treated as an illness rather than a process (Rothman, 1991). Midwifery steadily has gained in popularity since the 1970's and is seen by many (including a significant portion of the medical community) as a legitimate alternative to traditional obstetric care.

A growing number of groups in the United States promote the midwifery model of care. The modern midwifery movement in the United States promotes midwifery as an alternative to traditional obstetric care, educates about the pregnancy and birth processes, and works to ensure the availability of midwifery care in all 50 states through legislative activities. Some of these organizations explicitly acknowledge the consumer dimension of the decision to use a midwife. For example, Citizens for Midwifery, a national pro-midwifery organization, calls itself the largest, national, consumer-based organization in support of access to midwives (Citizens for

Midwifery, 2003). In particular, the midwifery movement has focused on a change in language that de-emphasizes the medicalization of the birth process; thus the movement's literature does not use the term "patient" to refer to the expectant woman. However, the choice of the term "consumer" as a replacement (as opposed to, say, "woman" or "mother") is potentially interesting for several reasons. First, given the emphasis on consumer empowerment in American society, use of the word "consumer" would seem to imply concepts such as choice and authority. Secondly, the word consumer is gender-neutral, taking away (to the degree possible) the gender dynamics typically found between female users of the healthcare system and the typically male medical authorities.

Statement of Problem

When patients are faced with the responsibility for making decisions in healthcare situations, how do patients function as consumers? What issues are most important to them? Where do they turn for information? How do they assert their authority in these decision-making situations? Specifically, what are the various issues that impact the decision-making environment for women who are choosing their birth attendant?

Purpose of Study

Generally, this study will seek to understand from a consumer economics perspective why women choose midwives and how they came to that decision. Approximately 89% of births in the United States are attended by physicians despite the fact that midwives have consistently higher patient satisfaction ratings than obstetricians, have lower caesarean-section rates (even when risk factors are controlled for in statistical analyses), on average cost less than obstetricians, and are the standard of care for low-risk pregnancies throughout the majority of the

world (American College of Nurse-Midwives, 2002a; Declercq, 1998; Declercq, Sakala, Corry, Applebaum, & Risher, 2002; Galotti, Pierce, Reimer, & Luckner, 2000; Howell-White, 1999; Kelly, 2002; Lay, 2000; Rothman, 1991). What factors influence women who choose midwives to challenge the status quo? How do women make the decision to choose a service provider not accepted by the majority of other consumers? Might a theoretical framework designed from consumer studies help us to understand better the current healthcare environment, specifically the process of choosing a birth attendant?

Research Questions

This study addresses several questions. When faced with a choice between traditional obstetrical care and midwifery care for the delivery of their babies, how do women think of themselves in the decision-making process? Do they consider themselves knowledgeable enough to find pertinent information and analyze the pros and cons of their alternatives? What sources of information do they consult and which ones are most influential? What characteristics are women looking for in their birth attendants? This information potentially is valuable both for theoretical exploration and for practical application. Other theories related to feminism or environmentalism have been used to study the decision-making process related to choosing a midwife, but consumer theory, with its emphasis on information and decision-making in market transactions, may increase significantly our understanding of this multifaceted process. Practically speaking, this information could be used to help provide information to women regarding their full range of options for childbirth. Additionally, all professionals who work in the maternity healthcare market may use this information to understand better what women deem as important aspects of the process of pregnancy and childbirth.

Listening to Women/Consumers

Qualitative research methods will be used to investigate the process of choosing a midwife. Relatively few academic studies have looked at the decision-making process of choosing birth attendants from a consumer's/woman's/mother's perspective. A qualitative study will help to uncover the underlying factors of this decision that may not be obvious to those outside the decision-making process. In this case, qualitative methods are better suited to investigating this relatively unexplored decision-making process than a survey instrument which necessarily must draw upon some base of knowledge to construct questions and, more importantly, to create response sets for those questions (Strauss, 1994). Quantitative methods require an understanding of the most important and significant issues relevant to the subject under study, while qualitative methods allow researchers to explore areas in which there has been little previous exploration as is often the case with patients in healthcare settings (Murphy & Dingwall, 2003). Most books written about pregnancy and childbirth, especially those in the popular press, are written by medical professionals, not by women who have gone through the process of childbirth. Approaching women who have made the decision to choose a midwife and asking them open-ended questions will allow them to discuss the issues they found significant to their decision-making process. Qualitative methods can be particularly suited to exploring issues in which there traditionally has been an imbalance of power based on gender, as typically has been true in the medical model of obstetrics (Oakley, 1981). The use of qualitative methods potentially can give voice to women who largely have been ignored in previous research on this subject.

Definition of Terms

It is important to define "midwifery" and how it is similar and dissimilar to physician obstetrical services. Many international healthcare organizations have adopted a standard definition for the occupation of midwife. According to Midwives Alliance of North America (2004) the following definition has been adopted by the International Confederation of Midwives, International Federation of Gynaecology and Obstetrics, and the World Health Organization:

> A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.
>
> She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counseling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service. (p. 2)

Midwives generally are classified as one of four types. A certified midwife is a person who has been educated in the discipline of midwifery and is certified by the American College of Nurse-Midwives (ACNM). A certified nurse midwife has been educated in both midwifery and nursing and also is certified by the ACNM. A direct entry midwife is an independent caregiver who has been educated through self-study, apprenticeship, midwifery school, or college-based program that is not nursing affiliated. A lay midwife is an uncertified or unlicensed midwife who learned through self-study or apprenticeship without a formal program of study.

Midwives have distinguished themselves from obstetricians by adopting the "midwifery model of care." This definition of midwifery care states that:

> The Midwives Model of Care is based on the fact that pregnancy and birth are normal life events. The Midwives Model of Care includes: monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle; providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support; minimizing technological interventions; and identifying and referring women who require obstetrical attention. (Midwives Alliance of North America, 2004, p. 3-4).

One of the most distinguishing characteristics of midwifery is its desire to limit technological interventions (such as anesthesia, labor-inducing drugs, monitoring devices, and surgery), though they are not opposed to the use of technological interventions as needed or requested by the laboring woman (Kennedy, 2002). Because of this ideological emphasis on limiting interventions, midwives generally are limited to practice with "normal, low-risk" pregnancies. The definition of a low-risk pregnancy varies from practitioner to practitioner, but generally includes no previous chronic illness that could threaten the health of the mother or

baby, low-risk factors for pregnancy-induced illness (such as gestational diabetes or preeclampsia), and, if it is the first pregnancy for the mother, younger than age 35. As only a small minority of cases have major complications (Smith, 1992), the vast majority of women would qualify for midwifery care. All states require that midwives carry malpractice insurance and most states require that midwives be associated with at least one obstetrician who may be called upon for assistance in the event of the presentation of a high-risk characteristic or medical emergency.

In practice, midwives generally spend more time with their clients than obstetricians and are more emotionally involved in the pregnancy and delivery process, an approach described by American Baby magazine as "less tech, more touch" (Kelly, 2002). A recent survey conducted by the Maternity Center Association found that midwives and doulas (a type of birthing assistant who does not deliver the baby, but attends to the mother's other needs during labor and delivery) had the highest satisfaction ratings for supportiveness during the pregnancy and birth process (Declercq et al., 2002).

Around the world, midwives deliver approximately 80% of all babies (MANA, 2004). However, in the United States, midwives attend approximately 10 to 11% of vaginal deliveries ("Number of women," 2004). The use of midwives increased by 117% during the 1990's in this country (American College of Nurse Midwives, 2002a). This increase in popularity also has influenced legislation. All 50 states offer licensing to certified nurse-midwives (states vary as to the licensing of direct-entry and lay midwives). Currently, 33 states require insurance companies to reimburse their customers for nurse-midwifery services and Medicaid covers midwifery services in every state. Additionally, certified nurse-midwives have the authority to dispense prescriptions in 48 of the 50 states.

In the southeastern state in which this research was conducted, midwives attend 14.9% of vaginal births. The majority of these babies are delivered by nurse-midwives in the estimated 171 practices with midwives found in the state (American College of Nurse-Midwives, 2002b). The state does not require that insurance companies reimburse for midwifery services; therefore, reimbursement is left to the policies set by individual insurance companies. The exception is Medicaid, which provides 100% reimbursement of midwifery services in all 50 states.

Delimitations

Women were recruited for this study through a combination of convenience and snowball sampling techniques. Recruiting efforts were focused on the larger metropolitan area of a major southeastern city. This city was chosen because women in this metropolitan area have access to a wide variety of physicians and midwives, both of whom may be found in practices of all sizes. Additionally, there are at least a half dozen hospitals from which to choose. Since the decision-making process is a central focus of this study, it was important to recruit in an area in which women have many options for whom attends and where they have their babies. Selection of women for the study was limited to those who had given birth with a midwife in attendance (or had planned a midwife-attended birth but had a physician delivery due to unforeseen complications). To minimize recall issues women were recruited for the study only if they had used the services of a midwife within the past three years.

To find women who fit these criteria, mothers' groups were targeted in the selected southeastern city. The specific mothers' groups that were contacted included women who had babies and small children who had not yet started school full-time. Participants were informed that they would be interviewed at least twice, with the first interview taking place in person and

the second interview taking place on the telephone to minimize any inconvenience they might experience in giving their time to the study.

Limitations

Because this is a qualitative study, care must be taken to limit the extent to which generalizations are made to populations beyond the specific persons interviewed. Women who had chosen midwives to attend their birth and/or had midwives attend their birth within the previous three years were recruited from a major metropolitan area in the southeastern United States. This limited the sample to women of reproductive age within a specific area of the country. The selection and recruiting methods yielded a group of women who were all white, middle to upper-middle class, and most of whom did not work outside the home. However, the greatest limitation to the findings of the study were the convenience and snowball sampling techniques employed to recruit interviewees. Due to the significant possibility of introducing bias into the sample of women selected for interviewing, great care must be taken when attempting to generalize any of the findings. However, the findings of this study will be useful in creating a foundation upon which other, more randomly selected samples may be explored. By first discovering the underlying issues that women must contend with when they choose a birth attendant, it will be easier in the future to create research plans that include instruments (i.e., surveys and questionnaires) more suitable to the use of random sampling techniques. The details of the interviewing process are discussed in depth in Chapter Three which deals with the methodological issues surrounding this study.

Researcher's Perspective

This study was undertaken using a consumer perspective. Specifically, the focus was on aspects of the decision-making process and environment that are most like those faced by consumers in service markets in general. Using a consumer perspective means that the researcher approached the decision-makers (in this case, women who had given birth using the services of midwives) as rational actors who use information to make a decision that best suits them and their situation at that point in time. An expanded discussion of the economic assumptions of rationality and information processing is found in Chapter Two.

Significance of Study

Studying the consumer aspects of this process seems an interesting and potentially significant new avenue of inquiry available for studying the decision-making process used by expectant mothers. By investigating the consumer aspects of healthcare decisions, research may uncover issues that will help guide policymakers as they deal with the state of the nation's healthcare system in the future. Given that consumer-based healthcare groups have been successful in shaping national obstetrical policy in countries such as Great Britain, study of consumer health issues in the United States will be an integral part of future policy development (Declercq, 1998). Understanding the roles which women feel they play in the decision-making process and the sources of information they find most accessible and influential will help us to understand how to empower women when making one of the most important decisions they will make regarding their own health and that of their children.

CHAPTER TWO

LITERATURE REVIEW

Researchers traditionally have studied midwifery from a sociological or women's studies perspective. They have studied different aspects of midwifery, from the historical role of midwifery in the United States to women and power in the birth process. Historical studies (such as Declercq, 1992; Eakins, 1986; Mitford, 1992; Rothman, 1991; Shroff, 1997) typically concentrate on aspects of midwifery such as the changing role of midwives in obstetrical care in the United States over time, analyzing their power and authority relative to the medical establishment, and the legal and cultural issues that have impacted the practice of midwifery. Other studies explored the role of women (mothers) in the birth process, focusing on delineating between "woman as active participant" and "woman as vessel" as a way of defining power and control in childbirth, including power differentials between women and medical professionals (Rothman, 1991; Zadoroznyj, 1999).

Sociological studies on issues surrounding the modern midwifery movement (1970's to the present) have analyzed issues such as insurance companies' policies regarding choice of birth attendant and acceptance of midwives by the modern medical establishment (Declercq, 1998; DeVries, 1996; Howell-White, 1997; 1999) and social factors influencing the choice of birth attendant (Galotti, Pierce, Reimer, & Luckner, 2000; Howell-White, 1999). Overall, many of these studies have focused on power differentials between women and the traditionally male medical establishment. A feminist approach is especially suited to informing the analysis, as feminism itself is concerned foremost with the lack of equality between males and females in

society due to patriarchal social values (England, 1993; Tong, 1989). Though many studies specifically do not address feminist ideology as a component of the modern midwifery movement, it is implied through their analyses of power. Rushing (1993) specifically linked the ideological components of feminism and science as the impetus for the modern midwifery movement in the United States.

Though consumer studies and sociological studies rarely have met on the topic of midwifery, there would seem to be a natural pairing of the two for the study of midwifery. Researchers who have analyzed the consumer movement have concentrated on power differentials and issues of authority, though their primary focus has been between consumers and suppliers (Mayer, 1989; Swagler, 1994). However, women have played a major role in the modern consumer movement (Mayer 1989, 1998) and marketing studies show that women tend to be more "active" consumers, for example being more likely to complain about poor service (Stichler & Schumacher, 2003). Given current trends in the United States, Johnson and Fansler (2002) propose that consumerism will become the prevailing ideology in healthcare markets. Since women make the majority of household healthcare decisions (Harris Interactive, 2001), it seems important to address the consumer aspects of a uniquely gendered process such as childbirth. Both feminism and consumer studies seek to promote a more equal relationship between traditionally superior and subordinate parties.

The fields of consumer studies and marketing have contributed to the understanding of healthcare issues in various ways. Generally, consumer studies have examined consumers' search for information and the unique aspects of selecting services as opposed to tangible goods. Marketing studies necessarily have a goal of providing information to providers/suppliers for the purpose of maintaining and increasing business, though this purpose need not be mercenary

because it often has an emphasis on customer satisfaction. Both fields have focused on the characteristics of consumers, and on satisfaction generally, but have not addressed specifically how midwifery services attract women through its unique set of characteristics.

Given that there is an increasing interest in midwifery in the United States, especially as healthcare costs skyrocket and the resources to pay for those costs dwindle (Seltman, 2003), expanding upon the consumer dimension of the decision-making process and midwifery as a service could contribute significantly to the base of knowledge used to guide the future of healthcare services. A review of the existing literature in consumer and marketing studies related to midwifery will help to elucidate the understudied aspects of this issue.

Consumer Information Search

Some of the assumptions found in neoclassical economic theory have been criticized as unrealistic. One assumption in particular, that consumers have perfect information, would imply that there is one market equilibrium price for every good, and therefore, there should be no variation in prices for the same good sold in different markets. While some variation may be due to differences in sellers' costs or instability in the market, George Stigler (1961) asserted that the ultimate price of a good can be different to different consumers. Differences in preference structures and opportunity costs affect consumers' willingness to search for the lowest price for the desired good. Thus, Stigler's theory of information search explicitly adds the costs of information search (direct costs and opportunity costs) to the price of market goods, while still accepting other neoclassical assumptions.

According to Stigler, the market price of a good does not have a single equilibrium; variation exists in markets. There may be different prices for the same good or there may be different goods with the same price. However, it is unrealistic to assume that consumers seek

perfect information for every good they purchase. A consumer will search for information as long as the expected gains from that additional search would exceed the expected costs of the search. Thus the dependent variable in Stigler's analysis is price.

General Studies of Consumer Information Search

Over the past 40 years, researchers have expanded upon Stigler's theory by analyzing many aspects of the information search process. These studies have explored various components of the process, such as consumer characteristics, market characteristics, product characteristics, and method of information delivery. The majority have studied consumers in the market for goods, rather than services. Additionally, many researchers changed the focus from price as the dependent variable to other variables that play a role in the information-seeking process.

Some important additions to Stigler's model include the non-price factors that can potentially influence the amount of information search undertaken by consumers. For example, Goldman and Johannson (1978) added external factors to their analysis of consumer information search. Two main categories of external factors were added to their model. The first category comprises additional shopping goals (other than lowest price) such as service, quality, and convenience while the second category is comprised of behavioral correlates to gains and costs of search such as the amount purchased (gain), consumers' perceived price dispersion (gain), the opportunity cost of their time (cost), and their search efficiency (cost). Similarly, Kiel and Layton (1981) divided information search into three dimensions. The sources of information dimension, brand dimension, and the time dimension create three separate areas in which consumers can devote their efforts. The amount of effort spent in each dimension then results in

various taxonomies of consumers. The researchers used the general categories of high search, low search, and selective search to reflect different consumer approaches to information search.

Rosen and Olshavsky (1987) created another category of search behavior seemingly not noted by other researchers. They developed the concept of "subcontracted decision-making." This type of information search happens when consumers turn information search and decision-making responsibilities over to others presumably more knowledgeable than themselves. Thus while some consumers would appear to do very little information search, they actually have placed the task in another's hands. This conceptualization differs from the information generally categorized as "advice" by most researchers, since the subcontractor is responsible for making the ultimate decision by acting on behalf of the consumer who will actually purchase and use the good or service. An example of subcontracted decision-making would be hiring a wedding consultant to plan and hire the appropriate service providers (i.e., florists and caterers) for the ceremony and reception. Subcontracting may play a potentially important role in healthcare markets, given the complexity of the information that consumers must digest.

Other researchers have theorized that information search can be comprised of activities not completed for a specific purchase of a good or service. Bloch, Sherrell, and Ridgeway (1986) developed the concept of "on-going search" to account for consumer information search outside of specific purchasing situations. Consumers constantly are taking in information around them. This ongoing information search may be for practical reasons (such as the eventual need for a new car) but also can take on hedonic and recreational motives as well. Thus, "window shoppers" or consumers who are "just browsing" may be involved in a more productive activity than previously thought. This notion of past accumulated information plays a role in the concept of "consumer sophistication" developed by Sproles, Geistfeld, and Badenhop (1978) which

reflects prior experience with goods, services, and the workings of markets and market prices, and subdivides groups of consumers based on experience and exposure. The product of "on-going search" becomes "memories" under the theoretical construction of consumer information search in research developed by Moore and Lehmann (1980).

However, all prior experience may not be memorized or recalled in the same way. Ganzach and Mazursky (1995) and Lynch and Srull (1982) incorporated a time dimension in their conceptualization of consumer information search, showing that the time delay between obtaining information and making a purchase decision in and of itself becomes consequential to choice. The longer the time lag between obtaining information and making a decision, the more likely the decision is to be consistent with the positive information, rather than the negative information. Graham (1981) also contends that the study of consumer behavior must take into account cultural differences in the conceptualization of time to understand properly how time becomes an intervening variable. According to Graham, Anglo culture is much more future-oriented than most cultures. Thus, time becomes a much less important factor for non-Anglo ethnic groups. Information search behavior then takes on a culturally relative aspect as well.

Jacoby, Speller, and Berning (1974) addressed an aspect of information search potentially quite relevant to consumers in healthcare markets—how consumers deal with large amounts of information. They contended that the study of consumer information search must take into account the amount of information that consumers can effectively use in the decision-making process. They found in their study that consumers can suffer from an information overload, which indicates that quality of information is more important than quantity of information. Too much information actually can discourage consumers from information search, by making them feel too overwhelmed to try to sort through the evidence. Research by Jacobson and Obermiller

(1989) also supports this hypothesis. Once information has been acquired, consumers may or may not process that information accurately or correctly. While Olshavsky and Summers (1974) found in their research that consumers' beliefs generally were consistent with their knowledge, Alba and Hutchinson (2000), Brucks (1985), and Park, Mothersbaugh, and Feick's (1994) findings indicated that may not be the case for many consumers.

In an era of consumer empowerment efforts by the government, non-profit consumer organizations, and newscasts that regularly incorporate consumer reporter segments, becoming an educated or savvy consumer can be a point of pride or satisfaction for an individual (Babin, Darden, & Griffin, 1994). Beatty and Smith's (1987) findings indicated that ego involvement was positively related to consumer information search. Their concept of "ego involvement" is similar to Duncan and Olshavsky's (1982) consumer beliefs about their ability as effective consumers, but is a bit broader. Ego involvement also includes the importance of the product or service to the consumer's ego or self-image. Avery (1992) also used a "consumer involvement" dimension in her research as a reflection of housewives' perception of their role as the primary consumer in the household. Duncan and Olshavsky (1982) learned that people's beliefs about themselves as consumers and the marketplace significantly helped to explain their information search behavior. Urbany (1986) found that the strength of beliefs also is important in predicting information search behavior. Punj and Staelin (1983), however, found in their research that consumer satisfaction was related to cost savings, not search itself, which would seem to support a more traditional interpretation of Stigler's theory.

Consumer Medical Information Search

There does not appear to be an abundance of literature specific to consumer information search in healthcare markets. A few researchers have investigated consumer information search

in relation to the selection of a new dentist (Coleman, Warren, & Huston, 1995) or physician (King & Haefner, 1988; Puig-Junoy, Saez, & Martinez-Garcia, 1998; White-Means, 1989). At least two other studies have included consumer information search as an independent variable in investigations of the demand for healthcare or healthcare coverage (Kenkel, 1990; Monroe, 1985).

It can be difficult to study consumer medical information search because there is little agreement on conceptualizing search in the medical market (White-Means, 1989). Information search can be directed toward several goals, such as choosing a healthcare provider, finding lower prices for services and healthcare related items (such as medications and medical devices), choosing between alternate therapies, and choosing between health insurance options. Much of the research on consumer medical information search has focused on price as the desired outcome to the efforts of search or the effect of search on demand for healthcare. Research that has focused, at least in part if not fully, on the price and demand outcomes of medical information search include White-Means' (1989) study of elderly consumers' search behavior for medical services, Kenkel's 1990 econometric study of demand for medical care, and Puig-Junoy, Saez, and Martinez-Garcia's (1998) study of the use of emergency rooms from an economic perspective. Hunt-McCool, Kiker, and Ng (1994) and Hay and Olsen (1984) each compared several different economic models of demand for medical care. Pauly and Satterhwaite (1981) calculated income and price elasticities for medical services based on the use of insurance and there have been similar economic studies of pediatric services (Goldman & Grossman, 1976) and health care in general (Eichner, 1998).

Other studies have focused on the information search process in healthcare markets, including King and Haefner (1988), Monroe (1985), and Coleman et al.(1995). Application of

the study of risk as an influence on information search behavior in the search process for dentists did not yield significant results (Coleman et al., 1995). However, risk theory seemingly has not been applied to other types of search (such as for cardiologists or oncologists) in which there would presumably be a greater sense of risk on the part of the consumer. King and Haefner (1988) found that when choosing a physician, patients were more likely to consult personal sources of information such as friends and relatives as opposed to external sources of information (such as ads and other physicians), though the more severely ill the patient was, the more likely s/he was to consult another physician for information. Monroe found in her study of families making decisions about healthcare plans and providers that socioeconomic factors, consumerism, and knowledge of HMO's did not significantly influence the decision-making process.

Consumer Behavior in Service Markets

The majority of research on consumer information search behavior has focused on consumer goods. Items such as electronics and appliances (Andrews, 1992; Beatty & Smith, 1987; Bloch, Sherrell, & Ridgeway, 1986; Brucks, 1985; Duncan & Olshavsky, 1982; Marmorstein, Grewal, & Fishe, 1992; Newman & Staelin, 1972; Rosen & Olshavsky, 1987; Sproles et al, 1978; Udell, 1966; Urbany, 1986), cars (Kiel & Layton, 1981; Newman & Staelin, 1972; Punj & Staelin, 1983; Ratchford, 1982; Slama & Tashchian, 1985; Srinivasan, 1986; Srinivasan & Ratchford, 1991), groceries (Avery, 1992; Jacobson & Obermiller, 1989; Jacoby et al., 1974; Moore & Lehmann, 1980; Rosen & Olshavsky, 1987), and gasoline (Goldman & Joahnsson, 1978; Marvel, 1976) seem to be the most commonly studied.

Fewer studies of consumer information search have focused on consumer services. Maute and Forrester (1991) studied consumer information search for banking services and

Ganzach and Mazursky (1995) investigated information search for laundry services. Information search in the financial services market (such as credit and investment services) has been analyzed by Lin (2002), Lee and Hogarth (2000a, 2000b, 2000c), and Chang and Hanna (1992). There also have been studies on consumer use of information after telecommunications deregulation and/or consumer switching behavior (Cude, 1989; 1990; Keaveney, 1995). Other research has tended to focus on services from a marketing perspective, rather than from a consumer perspective (Zeithaml, Parasuraman, and Berry, 1985).

This lack of attention to consumer information search for services may reflect the intangible aspects of services that may be difficult to operationalize or standardize across consumers. Economic theory posits that goods and services can have search, experience, and credence qualities. Search qualities are those aspects of a good or service that can be determined prior to purchase, such as the color, size, or style of an item. Items with search attributes are the easiest category of goods for consumers to inspect and compare before purchase. Experience qualities are those aspects of a good that a consumer cannot judge until a product has been used or consumed (Nelson, 1970). An apple, for example, would have both search and experience qualities. A consumer can see the size, shape, and color of an apple prior to purchase. However, the experience aspect of an apple (the taste) cannot be evaluated until the apple is eaten. Credence qualities are the aspects of a good or service that a consumer may never be able to evaluate, even if he or she has used or consumed that good or service (Darby & Karni, 1973). For example, if the apple has a sticker proclaiming "organically grown for a healthier family," it may be impossible for individual consumers to judge the validity of this claim.

Services typically rank high on both experience and credence qualities, which can make them difficult to compare in the marketplace. Olshavsky and Kumar (2001) proposed that

credence and experience qualities should be considered as the two extremes on a continuum in order to rank various services based upon their specific combination of qualities. Some consumer and marketing studies have explored experience and credence attributes of goods and services specifically. Many of these studies have focused on the experience (i.e., taste) and credence (i.e., nutritional value) qualities of food products (Caswell & Mojduszka, 1996; Issanchou, 1996; McCluskey, 2000; Ophuis & Vantrijp, 1995). Other studies have focused on services, such as higher education, and entertainment (Melton & Trevino, 2001; Neelamegham & Jain, 1999).

Acknowledging this combination of search, experience, and credence factors is particularly critical for understanding decision-making in healthcare markets (Barnes, 1985). Search attributes are obviously the easiest qualities for consumers to investigate, while experience and credence qualities are more difficult to investigate prior to purchase. Medical services may have search, experience, and credence characteristics. Maternal healthcare services definitely include all three categories of attributes. For example, physical environments of the doctor's or midwife's office and labor/delivery rooms would qualify as search attributes that can be investigated prior to purchase. Other aspects such as bedside manner and technical competence would qualify as experience and credence attributes.

Emons (1997) focused on services provided by "professionals," such as doctors, lawyers, mechanics, and repair technicians. Most consumers who need to contract for the services of professionals depend upon them as both experts as well as service providers. In the capacity of expert, professionals make specific recommendations to consumers. Consumers then decide whether or not to follow the recommendations. If they choose to follow the recommendations, they must find someone to carry them out. They may choose the person who made the

recommendations in the first place, though it is not guaranteed. Liebeskind and Rumelt (1989) used game theory to explore honesty and trust in the market for experience goods. Their analysis supports the theory that in a free market there is little motive for experts to make fraudulent recommendations. Emons (1997) came to a similar conclusion in his analysis of fraudulent experts in credence good markets, proposing that if consumers are able to process all available information, the free market structure itself will correct for dishonest sellers in credence markets.

However, whether most service markets, and healthcare in particular, in reality fit the definition of a perfectly free and competitive market is debatable. Kim (1992), who analyzed pricing of experience goods from a seller perspective, also used a free market framework with its accompanying assumptions and acknowledged that incorporating the possibility that consumers have incomplete information and the subjective nature of evaluating experience goods may produce more useful results. Laband (1991) proposed from his analysis of search and experience goods that higher-priced experience goods be regulated before lower-priced experience goods, as consumers perceive more risk in their purchase decision as price increases.

Ostrom and Iacobucci (1995) analyzed several service industries, exploring the effect of experience and credence aspects of services on consumers' evaluations. They found that credence goods (such as tax and medical services) often are considered more "critical" than experience goods (such as hotels and hair salons). Participants in their study were more price sensitive for experience goods and more quality sensitive for credence goods.

In general, studies investigating consumer information search in healthcare markets are scarce and have not yielded many significant findings. Most of these studies have focused on healthcare expenditures in general, with a few exceptions looking at search for specifics, such as dentists and use of emergency rooms. While both quantitative and qualitative methods have

been used, the limited number of studies regarding medical goods and services leaves many questions unanswered.

Consumer Choice and Birth Care

Two studies specifically have focused on the choice of birth attendant (Galotti et al., 2000; Howell-White, 1997, 1999). Both studies focused on women who were choosing between traditional obstetrical care and midwifery. Likewise, both studies primarily were concerned with differences between the women who chose midwives instead of obstetricians. Though the Galotti et al. piece also inquired about some kinds of information used in the decision-making process, it was not the focus of the research. Both studies were more concerned with the characteristics of the women than with the characteristics of the services they chose.

Howell-White (1997) used a combination of quantitative and qualitative methods to explore women's choice of a birth attendant. Both quantitative and qualitative methods were used with an initial group of 200 women who belonged to a Health Maintenance Organization (HMO) in New Jersey. As paying members of the HMO, the women were entitled to choose an obstetrician-attended delivery in a hospital setting, a certified nurse midwife-attended delivery in a hospital, or a certified nurse midwife-attended delivery at an off-site birthing center. The HMO costs to members were exactly the same for the women regardless of their choice of midwife or doctor. Thus, there were no financial incentives for the women to choose either type of birth attendant. In contrast, in an open-market system of healthcare, midwives are typically a less expensive option than obstetricians. The HMO sent each expectant woman a letter explaining each of the three options, and the philosophical perspective of midwifery, as well as resumes of the available obstetricians and certified nurse midwives.

Women in the study were given questionnaires at their first prenatal visit. Approximately six weeks after delivering, the researchers interviewed the women using a questionnaire that allowed for more in-depth and descriptive responses. The two time points were chosen so that previous attitudes toward childbirth and delivery options could be compared to actual childbirth experiences. Of the 200 eligible women first identified, 193 participated in both phases of the study. Of those 193 women, 117 selected a certified nurse midwife.

Howell-White (1997) looked at factors such as demographic characteristics, preexisting knowledge and definition of childbirth (i.e., whether childbirth is seen as a medical event or a natural event), social factors such as support of the father, and initial choice of provider to determine if there were differences between the women who chose midwives and the women who chose obstetricians. In general, Howell-White found that women who chose midwives were more likely to define childbirth as a "natural" rather than a "medical" event. Women who had indicated that they expected to learn significant amounts of information from their birth attendant, had support from their baby's father for obstetrician alternatives, and desired little control over the birth process (for example, not wanting to use labor stimulating drugs or other interventions but preferring to let "nature take its course") were significantly more likely to choose a certified nurse midwife for their pregnancy and delivery care. In general, the women in Howell-White's study chose their birth attendant based upon the birth attendant's "practice style" and how closely it matched the women's own beliefs about childbirth.

Galotti et al. (2000) interviewed 88 women who had either responded to signs or newspaper ads seeking research participants or who had come to the study by word of mouth. Several lines of inquiry guided their research. One objective was to learn if there were demographic differences between women who chose midwives and women who chose

obstetricians. Other objectives were to learn if the criteria for choosing a birth attendant and women's attitudes toward the decision-making process were different between the midwife and obstetrician users.

Like Howell-White (1999), Galotti et al. (2000) found that women who selected midwives as birth attendants felt they had support from significant others (such as the father of the unborn child, family members, and friends) for use of non-obstetrician birth attendants. In this study women who used midwives felt more control over various aspects of their births, which would seem to contradict the findings in Howell-White's study. However, this difference may be due to differences in defining the concept of "control over the birth process" rather than real differences in attitudes. In Howell-White's study, control over the birth process was presented in such a way as to infer that a woman who wanted control wanted to use interventions to make the delivery more predictable (such as the use of labor-inducing medications and the use of cesarean sections). The concept of control in the Galotti et al. study was presented as the ability to determine whether or not interventions were used and, if so, when (see Rothman, 2000 for additional discussion of control in the birth process). Thus, the findings in the two studies may be more similar than they appear at first sight. The Galotti et al. study also investigated how women made the decision between midwives and obstetricians and found that women who used midwives were more likely to rely upon "gut instincts" and habit than other women. The women in this study who chose midwives did not differ significantly from the women who chose obstetricians in their demographic characteristics such as age, education, religion, income, experience with childbirth, or birth order. While both groups of women seemed to think about the same types of issues surrounding the childbirth experience when making their decision regarding their birth attendant, it seemed that women who chose midwives were "more intuitive

and less analytic" than the other women. Since outcome statistics for midwives who attend low-risk births are at least as good, if not better than, those of obstetricians, Galotti et al. hypothesized that women who choose obstetricians after a more analytical decision-making process may have misconceptions about midwives.

One study specifically addressed the credence aspect of midwifery services. Adams, Ekelund, and Jackson (2003) explored the impact of occupational licensing on midwifery as a credence good. Adams et al. investigated the notion that occupational licensing can help mitigate the uncertainty that accompanies credence aspects of a good, as a way of providing "expert" evaluation that a layperson may not be qualified to judge. The logical result, then, of occupational licensing would be an increase in demand for the licensed service since consumers would be more confident in its quality. However, Adams et al., found that occupational licensing in the case of midwifery can reduce the quantity of midwifery services available by instituting overly restrictive licensing requirements for midwives. This ultimately serves to increase demand for obstetricians by decreasing the supply of licensed midwives. They assert that the nature of occupational regulation for midwives must be analyzed more closely to determine whether the licensing requirements are promoting or restricting consumer use of midwives, especially given the uncertain future of healthcare due to rising costs in the United States.

Healthcare Marketing

In the United States, marketing analysis has focused on the use of midwives as both a cost-saving method for the healthcare industry and as a way to generate satisfied customers. Hospitals in particular may see adding midwifery services to their obstetrical offerings as a way to stay competitive (Cutlip, 1997) and reduce costs (Fiesta, 1995). Since demand for non-

physician medical professionals is increasing (Blevins, 1995), marketing professionals also have begun to investigate choice in obstetrical services (Marshall, Javalgi, & Goebeski, 1995). Hospitals and doctors alike have a vested interest in creating satisfied patients/customers, particularly in obstetrics given the large numbers of women who use their services and the potential for repeat business. One study examined the relationship between patients' health status and their satisfaction with the healthcare services they had received. Powers and Bendall-Lyon (2003) found that patients who see improvement in their health status over time tend to view the services they received as more satisfactory than those patients whose health did not improve significantly.

Some studies combined both quantitative and qualitative methods to investigate the use of midwives. Healthcare "consumerism" and "consumer-directed" care, as it is often referred to in marketing literature (Geron, 2000; Halliday, 2000; Halliday & Hogarth-Scott, 2000; Johnson & Fansler, 2002; Stoil, 2000), denotes that patients often have choices in today's healthcare market. With regard to childbirth, women have options for who attends their birth (obstetrician, general practice MD, or midwife) and where they give birth (hospital, birth center, or at home). Childbirth is the top reason for admission to a hospital in the United States, ("Childbirth tops reasons for hospital stays," 2003), so much of the marketing literature concentrates on patient satisfaction and creating "relationships" with patients to ensure repeat business, a phenomenon with major industry impact in obstetrics. Marketers are seeing that treating patients as customers brings new dimensions to the healthcare environment, often bringing issues into the examining room and hospital that had previously only been seen as important in retail environments.

A specific area of marketing studies has focused on satisfaction with healthcare services in hospital settings. Jun, Peterson, and Zsidisin (1998) conducted focus groups of physicians

(four), administrators (six), and patients (six) at a mid-sized hospital in the southwest. Jun et al. isolated 11 constructs from their qualitative study and used those constructs to evaluate quality in hospital settings in general. Of the 11, patients and administrators both considered tangibles, courtesy, communication, understanding the patient, access, responsiveness, caring, and collaboration as the most important determinants of quality healthcare in hospital settings. Peltier, Boyt, and Schibrowsky (2000) analyzed specific components of obstetrical services and their impact on overall satisfaction and then used those findings to explore how service considerations can impact patient loyalty. Peltier et al. found that the most important factor in satisfaction with obstetricians was "friendliness" while the most important factor in satisfaction with nurses was the degree to which nurses gave laboring mothers control over decisions.

Halliday and Hogarth-Scott (2000) conducted research that examined women's expectations for their birth experiences within the United Kingdom's Public Health Service. Even though the UK has a publicly funded healthcare system, there has been increasing emphasis on treating patients as "customers" who have choices within the public system. They assert that to provide optimal services and build customer loyalty, providers must understand patients'/customers' expectations and then exceed them. Halliday (2000) contrasted midwives' and patients' expectations to see how closely they matched. Her analysis emphasized the importance of satisfaction (generally defined) and that midwives must be "nice" as a key component to generating and maintaining that satisfaction.

New Avenues in Consumer Studies—The Theory of Planned Behavior

Overview of the Theory of Planned Behavior

Many decisions are made during the course of a pregnancy, including the choice of who will attend the labor and delivery, what medications are taken, what interventions are acceptable,

and what methods are used to help labor progress. These decisions often impact and/or determine each other, given the nature of pregnancy and childbirth and the multitude of options available to women today. Also, a degree of uncertainty surrounds pregnancy and childbirth given that it is a natural, biological process, rendering it nearly impossible to guarantee specific outcomes. The Theory of Planned Behavior provides a potentially valuable way of modeling consumer behavior in this healthcare market under these complex conditions.

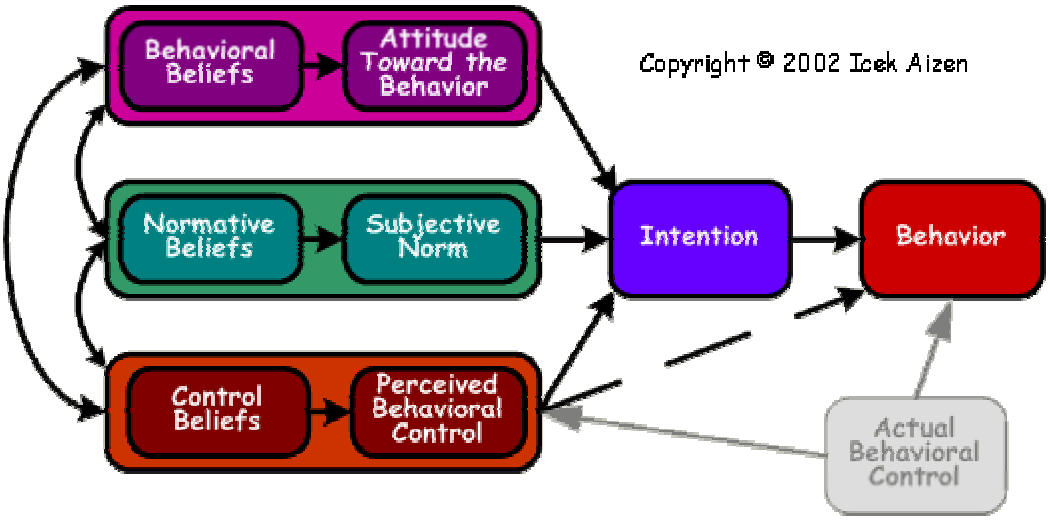
The Theory of Planned Behavior (TPB) is a theory developed by psychologist Icek Aizen (1985) that attempts to describe, explain, and predict behavior based on factors both internal and external to an individual. In its simplest form, the TPB assumes that a set of beliefs determines an individual's intention to perform a particular behavior. In turn, this intention is a determining factor in actual behavior.

The TPB is an expansion of the Theory of Reasoned Action (TRA) developed by Aizen and Fishbein in 1980. The TRA and TPB have in common the assumptions that individuals are rational beings who process information and consider the consequences of their actions before engaging in a behavior. In these ways, the TRA and TPB are highly compatible with classical economic theory. However, the TRA assumes that individuals have complete control over the behavior in question and does not allow for extenuating circumstances which could interfere with or prohibit an individual from completing that behavior. The TPB was developed to help understand behavior in situations in which an individual may not have complete and total control over their behavior, due to environmental factors, natural causes, emergencies, internal issues (such as pain thresholds or ability to be swayed by others), or a host of other possible intervening variables. Thus, the TPB links a variety of beliefs to the intention to perform a behavior, and

subsequently links intention, along with actual conditions that may or may not be under volitional control of the individual, to the actual behavior.

The factors assumed to precede the development of the intention to perform a behavior and its actual performance include "behavioral beliefs" which in turn affect "attitude toward the behavior," "normative beliefs" which in turn affect "subjective norms," and "control beliefs" which in turn affect "perceived behavioral control." All of these factors ultimately inform "intention." "Intention" and "actual behavioral control" are the immediate predecessors of "behavior." These factors, and the causal links between them, are illustrated below in Aizen's copyrighted diagram:

Figure 1: Graphic model of Icek Aizen's Theory of Planned Behavior



"Behavioral beliefs" are positivistic statements about the benefits or costs of a behavior. Individuals form behavioral beliefs from a variety of information sources that they have been exposed to and have judged to be accurate. It is at this point in the model that consideration is given to the influential sources of information, such as the media, other individuals, and personal experience. Behavioral beliefs then determine the individual's "attitude toward the behavior"

which is a subjective statement regarding the behavior. It is important to distinguish between behavioral beliefs and attitudes toward the behavior, as not all individuals who hold a positive belief necessarily will feel that it is relevant to their particular situation.

"Normative beliefs" are what the individual believes to be the expectations of other individuals or groups who are significant to the decision maker and the situation. Significant individuals may include spouses/partners, parents, friends, authority-figures, and peers and can change depending upon the situation in question. These normative beliefs then create a "social norm" for the decision-maker, which is the aggregation of the expectations of significant individuals. The sum of the normative beliefs yields the social norm which is the perception of outside pressure to conform to a certain behavior.

"Control beliefs" are beliefs about the environment in which the behavior is manifested and the degree to which (positively or negatively) those environmental factors will promote or discourage the intended behavior. These control beliefs then help individuals form their opinion of their ability to successfully or unsuccessfully negotiate these environmental factors, which is designated as "perceived behavioral control" in the TPB model.

The result of these factors is the individual's intention to perform the behavior. This intention, however, does not necessarily translate into behavior, as other factors can affect, impede, or prevent the intention from being realized in actual behavior. These other factors that are external to the individual are referred to as "actual behavioral control."

It is the inclusion of actual behavioral control that makes the TPB particularly well-suited to situations that may be approached with varying degrees of uncertainty, as is the case for many real-life situations. In particular, it has been popular in studying health-related behaviors. Specifically because of the predictive qualities of the model, it has been used to study behaviors

that are being encouraged (such as eating healthy food) or discouraged (such as using illegal drugs). Policies and programs aimed at changing or encouraging behavior then may be analyzed for effectiveness using the TPB model. Given the causal nature of the TPB, it often is used to analyze quantitative data with structural equation modeling which seeks to determine causal relationships in addition to association.

Empirical applications of the TPB have shown varying degrees of support for its components. Overall, the components of the model seem to vary in importance from situation to situation, and from group to group. The consensus of the empirical literature does seem to support the contention that the TPB exceeds the TRA in explaining and predicting behavior in circumstances that involve a degree of uncertainty with regard to external factors that can affect the implementation of an intention into a behavior. Other researchers have suggested modifications to the model, such as the inclusion of homogeneity/heterogeneity of beliefs (Armitage, 2003), anticipated regret (Abraham & Sheeran, 2003; Sheeran & Orbell, 1999), demographic and personality characteristics of individuals (Armitage, Norman, & Conner, 2002; DeBono & Omoto, 2001; Fekadu & Kraft, 2001; Pierro, Mannetti, & Livi, 2003; Saunders-Goldson & Edwards, 2004; Sheeran, Trafimow, Krystina, Finlay, & Norman, 2002; Sparks & Guthrie, 1998), and intentions and goal difficulty (Dewitte, Verguts, & Lens, 2003; Kurland, 1995). The success of these modifications/additions is mixed and seems highly dependent upon the concept's relevancy to the behavior under study. Additionally, many of the modifications/additions seem to be refinements of the original model's concepts, as opposed to major changes to the model.

Application of the Theory of Planned Behavior to Choice of Birth Attendant

The TPB seems potentially useful for studying the choices made in the process of choosing a birth attendant. Here is an example of how the TPB model could be applied to the desire to avoid epidurals during labor, a desire expressed by many women who choose to use midwives:

Behavioral belief: "The use of epidurals during labor can result in low-grade fevers in mothers which often causes the unnecessary administration of antibiotics to newborns."

Attitude toward behavior: "I shouldn't use an epidural for my baby's sake."

Normative beliefs: "My mom says an epidural is the only way to go, and my doctor says he doesn't want to deal with me if I don't have an epidural."

Subjective norm: "Most people believe epidurals are the way to go."

Control beliefs: "Nurses will try continually to persuade me to have an epidural."

Perceived behavioral control: "My husband has agreed to support me so I don't give in to the pressure to have an epidural."

Intention: "I will not have an epidural during labor and delivery."

Actual behavioral control: A) Everything goes as planned and the woman has complete control over her decision not to have an epidural, or B) despite her wishes, an epidural is needed to provide her rest so that she may regain sufficient strength to finish her labor and delivery vaginally; uncontrollable trembling due to nervous system overload requires administration of an epidural; a cesarean section is required and an epidural is used to anesthetize the lower half of her body so that she may be awake for the delivery; during the course of laboring others in the labor/delivery environment convince the woman to have an epidural.

Behavior: A) No epidural or B) epidural.

The Theory of Planned Behavior presents a new, comprehensive way of modeling consumer behavior in healthcare markets. Conversely, a qualitative study of women who chose midwives can help to elucidate the parts of the model, how they are related, and what other factors could be helpful additions to the TPB. This deeper analysis of labor and delivery intentions and behaviors could help to increase the explanatory and predictive power of the TPB model, particularly for consumers negotiating potentially complex issues in obstetrical healthcare market.

Methodologies Used in Consumer Information Studies

Researchers have studied consumer information search using several different methodologies, from survey research (self-reporting of behavior) to experimental design (typically using computer simulations) and by direct observation of information search behavior. The different methodologies have produced results that are at times at odds with one another. It is important to note that the amount of explained variance in information search behavior is typically very low in most studies (Duncan & Olshavsky, 1982). Thus it appears that the operationalization of information search concepts is very difficult.

The vast majority of these studies have relied upon surveys of behavior based on respondent recall. Survey collection of self-reported search behavior was used by Andrews (1992), Avery (1992), Beatty and Smith (1987), Bloch, et al. (1986), Duncan and Olshavsky (1982), Gupta and Ratchford (1992), Kiel and Layton (1981), Punj and Staelin (1983), and Slama and Tashchian (1985). Studies that have used self-reported measures of consumer information search behavior typically have yielded the weakest results, generally due to two main factors. First, closed-ended survey questions may miss many aspects of what respondents

consider to be information-seeking behavior. Second, respondents may have trouble recalling the exact nature of their information search and, as a result, omit some search activities.

Experimental designs involving consumer decision-making under controlled (typically laboratory settings) situations have attempted to overcome the problem of respondent recall. Brucks (1985, 1988), Ganzach and Mazursky (1995), Jacobson and Obermiller (1989), Jacoby et al. (1974), Maute and Forrester (1991), Moore and Lehmann (1980), Rosen and Olshavsky (1987), Sproles et al. (1978), and Urbany (1986) used experimental designs. These methods still typically limited consumers to a prescribed list of types of information search. Some experimental designs have attempted to overcome the artificial nature of information seeking under laboratory settings by creating time lags between information requests and responses, to better simulate the extra effort associated with finding certain types of information.

In an effort to investigate consumer information search, some surveys have combined two different types of data collection methods. Marmorstein et al. (1992) used both a survey and experimental design to compare consumers' perceptions of the value of time spent in price-comparison shopping. Newman and Lockeman (1975) used both a survey of self-reported behavior and field observation of shoppers conducting information search for ladies' shoes. Importantly, Newman and Lockeman found that their survey method significantly under-reported search behavior compared to the data collected by field observation. This finding suggests that either respondents have trouble accurately recalling their search behavior or that research instruments are not refined enough to accurately reflect the vast number of consumer information search behaviors. Considering that the literature in general has found that consumers conduct only limited information search in most cases, replicating this finding over several product categories would significantly affect the way consumer behavior is seen.

Previous research that applied information search directly to healthcare decisions has used a combination of survey and interview techniques. Among the studies that focused on healthcare decisions in general, Kenkel (1990) and Monroe (1985) used self-reported questionnaires to assess information in the medical decision-making process. Several researchers (Coleman et al., 1995; Puig-Junoy, Saez, & Martinez-Garcia, 1998; White-Means, 1989) who investigated the process of choosing a new physician or dentist also used data collected through surveys. King and Haefner (1988), however, interviewed their subjects in person regarding the search for a physician, using a combination of open- and closed-ended questions.

Two studies have focused on choice of birth attendant (Galotti et al., 2000; Howell-White, 1997, 1999). Howell-White used a combination of surveys and interviews while Galotti et. al. relied solely upon interviews. In contrast, most sociological (non-consumer oriented) studies of midwifery have used personal interviews and qualitative analyses (see, for example, Eakins, 1986; Lay, 2000; Shroff, 1997; Zadoroznyi, 1999).

What is Missing?

Research about midwifery from sociological and women's studies perspectives has focused on power differentials between women and the people who attend their birthing experiences and the ideological aspects of the modern midwifery movement. Most consumer and marketing studies have investigated the characteristics of women making the choice between physician-attended and midwife-attended births or the general satisfaction of women who have used various types of obstetrical services during birth. What is lacking is an analysis of what women today are looking for specifically in the services they choose for care during their pregnancies and birthing experiences. While the vast majority of expectant women are most

concerned with having the optimal outcome to their pregnancies (i.e., a healthy baby), there are other aspects to obstetrical services that also would seem to be important to women. By talking with women about their decisions to use midwives, this study seeks to determine the other dimensions that are important to these women about the process and experience of giving birth and how they come to their decisions. These findings could influence how information is delivered to consumers in the market for pregnancy and childbirth services, and potentially in other consumer healthcare markets as well.

CHAPTER THREE

METHODS

There are two main questions of interest in this study. First, why do women choose midwives to deliver their babies? Second, what sources of information do they consult and what influences them in their decision-making process? Because women's experiences in this decision-making process, especially in consumer research, have been underrepresented, qualitative methods provide the opportunity to explore in detail what women want for their birth experiences.

Relatively few academic studies have looked at the decision-making of women choosing birth attendants. A qualitative study will help to uncover the underlying factors to their decisions, since there is little previous research to guide the interviewer in questioning these women. Conversational interviews were expected to yield greater detail on this topic than a survey that used quantitative methods and relied upon previous research and theory to construct questions and response sets (Strauss, 1994). Qualitative methods have gained acceptance in the area of healthcare research as vital to understanding patient-practitioner interactions (Murphy & Dingwall, 2003). In addition, they are becoming more popular with consumer and market researchers investigating consumer decision-making (Davies, 2000).

Research Plan

After a group of women was selected for the study, they were interviewed twice to explore the process of choosing and the experience of using a midwife for the birth of a child. The first round of interviews was conducted in person and was purposefully general to elicit

women's experiences in their own words. After all of the women in the sample were interviewed once, the interviews were transcribed and analysis was started to find themes and trends in the descriptions of their experiences. This analysis informed the questions asked in the second round of interviews.

Qualitative analysis is an iterative, rather than a linear, process requiring that data collection and analysis be conducted at times simultaneously to guide the study as important themes emerge that should be followed and explored. Whereas quantitative research follows a process of reviewing literature and creating hypotheses for testing, qualitative analysis is a more inductive endeavor that requires some data collection to determine the appropriate literatures to research and the path that subsequent data collection should follow (Heath & Cowley, 2003).

Selection of Women for Participation

Because the decision-making process is a central focus of this study, it was important to recruit in an area in which women have many options for who attends and where they have their babies. A major southeastern city was chosen because women in that metropolitan area have access to a wide variety of physicians and midwives and both are found in practices of all sizes. Additionally, there are at least a half dozen hospitals in the city from which to choose. Importantly, the chosen metropolitan area had a sufficient number of midwives in practice so that when "midwifery" was brought up, the same practice did not immediately come to mind for most women interviewed. In many smaller cities or towns there may be but one midwife practice, which could heavily bias the interviews toward the particular midwives in that practice or the clientele whom they serve. In addition, conducting interviews in a metropolitan area avoids another possible bias, the frequently negative perception of midwives in rural or

underserved areas whose patients are primarily Medicaid recipients and/or the indigent (S. Hodges, personal communication, May 1, 2003).

Selection of women for the study was limited to those who had given birth within the past three years with a midwife in attendance (including those who had planned a midwife-attended birth but had a physician delivery due to unforeseen complications). Because interviews were conducted after the women's experiences of choosing and delivering with a midwife (as opposed to during the decision-making process), the three-year limit was used to avoid potential recall issues such as remembering the specific interventions used during labor and delivery or the demeanor of maternal health professionals in attendance. The three-year limit also served to control for changes in legislation or sources of information (such as widespread use of the Internet) that may have influenced women's decisions in one time period but not in another.

Women were recruited for this study through a combination of convenience and snowball sampling techniques. Though there can be significant drawbacks to the use of convenience and snowball sampling techniques (most notably, the lack of generalizability), for this study there was no "database" of women from which to draw a sample. Further, it would be very difficult to find enough participants through a more random sampling method (such as a mass mailing in which adult females in households are asked if they have ever used a midwife to deliver one of their children, and, if so, would they contact the interviewer to schedule an interview). The results of the qualitative data analysis, while not generalizable, will be descriptive enough to help enlighten future lines of inquiry.

To find women who fit the criteria, mothers' groups were targeted in the chosen southeastern city. These groups were found on the Internet using geographic-specific searches. Two mothers' groups in particular were used as they both have large numbers of groups

throughout the United States; do not base membership on religious status; do not charge large membership dues; offer a variety of meeting places, times, and dates; and only require that women have babies or small children as a condition of membership. A third group was contacted that serves as a source of information and support to mothers, again without regard to religious affiliation, without dues, and with a variety of meeting times and places so as not to exclude women who had responsibilities that might exclude them, say, from meetings that were held exclusively during the day or at night. The mothers' groups that were contacted typically included women who had babies and small children who had not yet started school full-time.

Women were not recruited from midwifery practices, as current patients would still have been in the process of decision-making and giving birth. In addition, recruiting women from midwifery practices may have created confidentiality issues for the practice itself. Recruiting women from mothers' groups avoided issues that may have arisen from practice-specific matters (such as having midwives join or leave the practice, joining or dropping out of specific HMO's or preferred-provider lists, or moving or closing practice offices). Such issues potentially could have affected most or all of the women recruited if subjects had been recruited from midwifery practices.

The researcher sent emails to group leaders and contacts, outlining the purpose of the study and the selection criteria. Potential participants were given the purpose of the study and the educational background of the interviewer and told that the research was being conducted for completion of a dissertation. Participants were informed that they would be interviewed at least twice, with the first interview taking place in person and the second interview taking place on the telephone to minimize any inconvenience they might experience in giving their time to the study. No compensation was offered to participants.

The researcher offered to come in person to mothers' group meetings to introduce their members to the study, but every person contacted who responded either forwarded the email to her group members or announced the study at a scheduled meeting without the researcher in attendance. Women then volunteered by using the researcher's contact information found in the introductory email sent to the group leaders. Women who volunteered to participate contacted the researcher either via email or telephone. The emails and announcements elicited a positive response of approximately 25 respondents. During the first round of interviews, another three respondents were recruited by women who had been interviewed and gave study information to women they knew who met the selection criteria. The remaining two women were found via personal connections to the researcher (one by word-of-mouth about the researcher's dissertation topic with a work colleague and one met by the researcher at a midwifery-related meeting). The 30 women interviewed were recruited from a variety of areas within the metropolitan area of the city and approximately 18 midwifery practices and 25 midwives were represented in the interviews. The women gave birth in a variety of settings, from some of the smallest hospitals in the area to the largest hospital in the city, and five women gave birth at home by choice.

It is difficult, if not impossible, to accurately estimate prior to beginning data collection the number of interviews that need to be completed due to the nature of qualitative data analysis. Ideally, a researcher will not stop collecting data (in this case, interviewing) before a point of "theoretical saturation" is achieved (Strauss, 1994). In essence, theoretical saturation is the point at which the researcher is learning nothing new or is able to predict what his or her respondent will say in additional interviews. Theoretical saturation was reached during interviews with the first 30 women who volunteered to participate in the research. Women who contacted the

researcher after this point were not interviewed, but their information was kept on file in the event that additional women were needed for the study.

The first interview with each woman was conducted in person between September and December of 2003. Interview arrangements were made via email or on the telephone. Women were allowed to select the time and place of the first interview. Two-thirds of the interviews were conducted in their homes. The remaining one-third were conducted in a variety of settings including restaurants, park playgrounds, coffee shops, and malls. The vast majority (25) of women were stay-at-home mothers and requested that the interviews take place during the day on a weekday, though three interviews were conducted at night or on weekends. In this first round of interviews, most lasted between one and two hours and all were audio taped by the interviewer. The second round of interviews was conducted by telephone during June and July of 2004. These interviews also were audio taped and generally lasted between 10 and 30 minutes. During this interview women were given the option of choosing the name they wanted used in the discussion sections of the research document.

Sample Characteristics

Twenty-five women who were interviewed were stay-at-home mothers. Another three women worked full-time and two women worked part-time or had home-based direct marketing businesses. Five women had children they currently were home schooling, which constituted a significant time commitment each week. The women ranged in age from 26 to 41, and all were Caucasian. Their household incomes fell between $30,000 and $150,000 and all were married and lived with their spouses. All women had at least a high school diploma. Most women (28) also had education beyond high school such as technical education, a year or more of college, an associate's or bachelor's degree, or a professional degree. Nine women had one child; 14 had

two, and the remaining seven had three or more children. Children were present for approximately one-half of the interviews, but conversations were limited to the researcher and mother (i.e., no other adult was an active participant in the conversation).

Interviews

The In-person Interviews

After having the women sign consent forms (as approved by the University of Georgia Institutional Review Board, project number 2001-10253-4) outlining the details of the study and their rights as participants, the tape recorder was turned on and the interview began. The women first were asked to give the number of children they had and how old they were. If they had more than one child, they were asked which pregnancies and births had been attended by midwives. Women then were asked how they had made the decision to choose a midwife and to describe their experience(s). These simple questions generated the majority of the interview, with a few questions throughout the interview to clarify or expand upon something the women had brought up. The women interviewed for this study were extremely open and forthcoming about their experiences and gave rich and detailed descriptions of their thoughts, information-seeking activities, and pregnancy and childbirth experiences. The interviewer was a 35 year old female who had no children. Speaking with a woman may have made the women who participated in the research more comfortable discussing a sometimes sensitive and personal topic. Additionally, nearly every woman asked the researcher if she had children, and upon hearing that she did not, went into detail to explain what happens during pregnancy, labor, and delivery to someone who had never been through the same experience.

Though a more detailed interview schedule initially was developed prior to sample selection, several preliminary interviews yielded a wealth of information by just asking "how did

you decide to use a midwife?" and "tell me about your experience(s)." Having a detailed list of questions on a piece of paper ultimately seemed more distracting than useful for the first round of interviews that focused on "discovery" of issues relevant to this process. To the extent possible, interviews were conversational in nature to allow the women to bring up the issues and events that were most relevant to their experiences. No detailed interview schedule was used, with the exception of an index card with prompts for the questions mentioned above. Demographic information (age, marital status, education, current and previous employment status, and gross household income) was collected at the end of the interview. An example of the additional questions asked to clarify or expand upon something the woman had said would be:

Interviewee: "I read everything I could get my hands on when I found out I was pregnant."

Interviewer: "Really? What did you read?"

Thus, additional questions that were asked by the interviewer were dependent upon the issues women chose to discuss when describing their experiences.

At the end of each interview, the researcher made written notes about the interview itself, noting aspects about the physical environment, interactions between the people in the interviewing environment, general mood and demeanor of the woman being interviewed and any other details that would create a written record to capture experiences during the interview that would not have been documented on an audiotape. After the researcher listened to the taped interviews, they were transcribed. The first three tapes were transcribed by the researcher, but at that point two professional transcriptionists were employed to transcribe the remaining tapes in a more timely fashion. As the researcher received the transcripts, they were compared to the

audiotapes for accuracy. The transcript files then were entered into a database for use with the NUD*IST software. Additionally, printed copies of the transcripts were collected in a notebook.

Telephone Interviews

Women were contacted by telephone for a second interview for several reasons. First, the second interview allowed for exploration of issues brought up in the first interview that were unclear or warranted additional inquiry. Each interview transcript had been reviewed and notated for additional clarifying questions, and was reviewed again immediately before starting the telephone interview. Second, the women were asked a second set of questions that had been developed after an initial analysis of the data collected (as described in the next section) in the first round of interviews. These questions were:

- What were your specific goals for labor and delivery?
- Did you receive specific information regarding hospital policies?
- Did you know your rights as a patient?
- How confident were you of your own knowledge regarding labor and delivery?
- Do you put much effort (i.e., research, reading) into other healthcare related decisions?
- If you had to pay out of pocket because midwifery services were not covered by your health insurance, would you still choose a midwife?

If a woman already had addressed a question in the initial interview (as determined by reviewing the transcript), that question was omitted during the telephone interview. Lastly, women were asked if there were any additional issues they would like to bring up related to the study. The telephone interviews were audiotaped and transcribed by the researcher. These files also were entered in the NUD*IST database and printed and filed in the project notebook.

Data Coding and Analysis Methods

The main tradeoff between quantitative methods and qualitative methods is one of generalizability for richer detail. While the goal of a quantitative study may be external validity, one of the main goals of qualitative research is construct validity (Trochim, 2000). Construct validity is the degree to which the constructs or themes that the researcher develops from the data (in this case, from interviews) actually represent the ideas and phenomenon expressed by the participants. Construct validity also might be seen as the degree to which the data actually reflect and support the theories to which the researcher connects them. According to Trochim (2000), "when we claim construct validity, we're essentially claiming that our observed pattern--how things operate in reality--corresponds with our theoretical pattern--how we think the world works" (p. 3). Interviewees will tell their stories and answer questions, but the researcher must find themes and develop constructs from them to represent the findings more succinctly to others.

This exploratory study used a "constant comparative method" (Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1990). This method is particularly beneficial for exploratory qualitative analysis because it requires that data be analyzed continually while it is still being collected and written up. This method allows the collection of data to develop continually to follow new lines of inquiry that emerge from the data already collected. Ratcliff (2002) summarized the steps involved in constant comparison as follows:

1. Begin reading data (in this case, transcribed interviews).
2. Look for indicators of categories and begin to name and code them.
3. Compare coding between transcripts.
4. When consistencies in coding are found between transcripts, begin to develop categories.
5. Start to formally isolate categories within the data.
6. Analyze the comparisons and categories.
7. When no new codes are being found, assume to be in a state of data saturation.

8. Look for a central focus among the categories that will become an axial or even core category for the data.

The coding process involves several different stages of analysis, including open coding, axial coding, and selective coding (Strauss, 1994). Open coding refers to the initial stage of coding in which general codes are formed and each transcript is analyzed thoroughly for possible coding categories. Axial coding is the second stage of analysis in which specific codes are analyzed intensely one at a time for the greater meanings and connections in the dataset as a whole. Selective coding is analysis of the relationship between core categories and related categories.

Several stages were involved in the coding process in this study. Every interview was tape recorded and then transcribed verbatim by either the researcher or two hired transcriptionists. After proofreading the transcripts and comparing them to the audiotapes for accuracy, the researcher then began coding each individual transcript, creating "codes" that represented the issues that the women brought up during the interviews. Once each transcript had been coded in this initial stage of open coding, the researcher compared the codes between the transcripts for common themes. This axial coding gradually lead to a more refined qualitative coding system that could be applied to all of the interview transcripts. The last stage, selective coding, identified the core issues that were most important and related the other categories to those core issues.

The following example is illustrative of the coding process for this study. The code of "hospital" was noted in all of the preliminary readings of the transcripts. As it became evident that there were themes running through each interview, "hospital" became a category that was then formally analyzed in and of itself in the data. Refinements were made, such as isolating the issues of "policies" and "nursing staff" within the category of "hospitals" (axial coding). This

process was continued until no new categories and codes were identified. Finally, the codes and categories were analyzed for relationships, which in this case also included applying theories of consumer behavior. When specifically applying consumer information search theories, which had been an original theoretical interest for the research project, the issues and decision-making process that the women were describing appeared to follow quite closely Aizen's (1985) Theory of Planned Behavior model of decision-making. Thus all of the questions asked during the telephone interviews were related to these two theories specifically, in order to validate their usefulness for describing and explaining consumer behavior in the maternal healthcare market.

To assist with the qualitative process, data were entered and processed with the assistance of NUD*IST software for code-based qualitative analysis. Qualitative software is a data-management tool that helps the researcher organize and catalog data and subsequent coding and notes. NUD*IST is generally recognized as one of the best and most commonly used computer-assisted qualitative analysis software packages in the social sciences (Barry, 1998). The benefits of NUD*IST include flexibility in coding and recoding, project management capabilities, and the ability to conduct sophisticated searches for terms and codes within the data. Additionally, NUD*IST allows the researcher to concentrate on documents (in this case, interview transcripts) individually while simultaneously being able to search and code in the entire data set. It must be noted, however, that NUD*IST does not analyze the data per se, yielding "results" as one produces with quantitative analysis software such as SPSS or SAS. Instead it assists the qualitative researcher in the process of managing the information generated in the qualitative research process. The researcher, not the software, solely generates conclusions drawn from the data.

The process of coding leads to the discovery of emergent themes in the data (interviews). It is these emergent themes that will be used to draw conclusions and open new lines of inquiry into the process of choosing a birth attendant. Since there is no hypothesis testing, *per se*, in qualitative data analysis, the themes primarily will be used to paint a picture of the decision-making process that the women interviewed used to make their choice of birth attendant and whether one or more consumer theories may represent adequately the decision-making process.

Conclusion

Given the lack of previous research on consumer medical information search and the role of consumerism in the choice of birth attendant, a qualitative approach seems the best method for generating the greatest amount of information regarding women's feelings and attitudes toward the decision-making process. The qualitative process will allow women to have their stories heard in their own voices, while also providing the groundwork to refine the concepts that might be useful in future research based on more generalizable samples of women.

CHAPTER FOUR

INTERVIEW FINDINGS

The women who participated in this study expressed a variety of beliefs, experiences, and opinions. There were some issues that all or most of the women agreed upon, while there were other issues with less overall consensus. This chapter discusses the women, their descriptions of making decisions in the maternity healthcare market, and the outcomes they experienced after making choices about things such as birth attendants, birth environment, and use of medical interventions. The women also described the social environments in which they made their decisions and how those environments, which included family, friends, and medical professionals, impacted their beliefs and behaviors. Their shared experiences serve to illustrate in detail what some women experience on their journey to motherhood and what changes, if any, they would have made.

Participant Demographics

A total of 30 women were interviewed for this study. There was a wealth of experience in this group as they had given birth a total of 65 times and had a total of 66 children (one set of twins), representing 63 vaginal deliveries and two cesarean-sections. Nine women had one child, 14 had two children, four women had three children, two had four children, and one woman had seven children. The women ranged in age from 26 to 41 and their children were 2 months to 19 years old. All but two women were recruited through their ties to mother's groups; one was recruited at midwifery-related meeting and one through a personal contact. All participants were white and all currently were married.

Sixteen of the women had bachelor's degrees in a variety of disciplines, from business to education to mathematics. Three women had advanced degrees, nine women had associates' degrees or some college, and two had high school diplomas. Three women currently were working full-time and two were working part-time or occasionally (for example, with home-based direct-marketing type business that sell products through catalogs and parties). The remainder were full-time stay-at-home mothers (three of whom were home-schooling their children). All but one woman had worked full-time outside the home before having children. Some of the women (23) were born and raised in the state while the others had moved here for their own careers or their husbands' careers.

To get a general sense of their economic status, recipients were shown cards with income categories of "less than $30,000," "$30,000 to $50,000," "$50,000 to $80,000," "$80,000 to $120,000," "$120,000 to $150,000" and "more than $150,000" and were asked to choose the category that best represented their pre-tax annual household income. Eight of the recipients fell into the "$30,000 to $50,000" category, eight were in the "$50,000 to $80,000" category, nine were in the "$80,000-$120,000" category, and five were in the "$120,000 to $150,000" category. For the 25 women who were stay-at-home mothers exclusively, household income was their husbands' earnings. The 30 women generally would be considered middle- to upper-middle class, living lives that were comfortable but not extravagant. Generally speaking, these women and their households were quite similar to others in this Metropolitan Statistical Area (MSA). According to the U.S. Census Bureau (2001), the largest age group in this metro area was 25 to 44, 50 percent of households contain a married-couple family, 54 percent have a high school diploma and/or some college while 33 percent have a bachelor's degree or higher and 68 percent live in single-family dwellings. Demographic information is summarized in the following table.

Table 1

Demographic Information

Characteristic	Range/Frequency	Characteristic	Range/Frequency
Age	26 to 41	Income	
Education		$30,000-$50,000	8
High School	2	$50,000-$80,000	8
Associates	9	$80,000-$120,000	9
Bachelors	16	$120,000-$150,000	5
Masters	3	Number of Children	
Employment		One Child	9
Stay-at-home	25	Two Children	14
Full-time paid	3	Three Children	4
Part-time	2	Four Children	2
		Seven Children	1

All of the women had used the services of a midwife within the three years prior to the interview. Of the 65 deliveries they represented, midwives attended 44 deliveries and obstetricians attended the other 21 deliveries. Seventeen of the women had used only the services of midwives for all of their birth experiences, though one woman who delivered her first child with a midwife actually had seen an obstetrician until her eighth month of pregnancy when she switched to a midwife. Of those 17, eight women were “first-timers,” having used midwives for their first and only birth. The remaining 13 women had used obstetricians for one or more births and then switched to midwives for subsequent births.

Five of the 30 women had given birth at home, with a total of nine homebirths among them. Two of the women had given birth at home exclusively. The women who had given birth exclusively at home were not different from the other women in terms of education or household income. They also expressed similar concerns and desires regarding their pregnancies and birth experiences. The one area in which they did seem a bit different from the mothers who had given birth exclusively in hospitals was that they were more aware of the legal and political issues surrounding childbirth (such as laws for practicing midwifery and insurance reimbursement issues) and seemed more active in the midwifery movement. For example, while many women (15) expressed concern about the potential hazards of medical interventions commonly used during labor and delivery, all five mothers who had given birth at home expressed concern about these interventions and cited them as one of the major factors contributing to their decision to give birth in a non-hospital environment.

All of the women's husbands were present for their midwife-attended birth; with rare exception, they also had been present for previous obstetrician-attended births. Some women also had relatives such as parents, siblings, children, and other close family members in the room. Friends also attended some births. Three women employed professional labor assistants known as doulas who are specially trained to support women during labor and delivery (though they are not medical professionals). At most births, the husband cut the umbilical cord although there were instances in which one of the children (including a nephew who dreamed of being a doctor one day) or the midwife cut the cord.

Interviewing Environment

One-third of the interviews were conducted in public settings such as malls, restaurants, workplaces, or public parks. The other two-thirds were conducted at the woman's home.

Children were present at all but four of the interviews conducted in public places. They were present at all of the home interviews, though in three of the interviews the babies remained in their rooms napping during the entire interview. The most popular times for interviews were 10 a.m., 11 a.m., or 1 p.m., which coincided with infants' naptimes. Most interviews lasted about an hour, though some were longer. It was not unusual for infants to awaken before the end of the interview and to be brought into the room. When interviews were conducted with women who had older babies, toddlers, or small children, the children typically played nearby or watched a video. When the interviewees brought children to interviews conducted in public places, they either played with quiet activities such as crayons and paper or ate a snack during the interview. All of the children were very well-behaved, and the occasional bit of fussiness usually was taken care of quickly.

Eighteen of the interviews conducted in homes were in single-family (unattached) dwellings in suburban subdivisions and housing developments. Two interviews conducted at homes were in townhome-style (attached to other housing) units. The interviews usually took place in the living room, kitchen, or dining room. While most interviews were conducted over a cup of coffee, sometimes the mothers were engaged in other activities, such as spoon-feeding children, breast-feeding, preparing meals and snacks, folding laundry, or changing baby's diaper while they talked about their childbirth experiences. There was typically little interaction between the interviewer and children present, as the children were involved in whatever activity was at hand (toys, videos, or snacks). It was not unusual for children who were snacking to offer to share with the interviewer whatever they had. Toddlers with pants around their ankles greeted the interviewer at the front door at two of the interviews and one toddler waved a cheery hello from a potty chair.

The homes were very similar in that they were decorated with lots of family pictures and children's toys and books. About a quarter of the homes had cats and dogs in and out of the room during the interview, including one dog who made his presence known on tape by belching into the microphone on the table. Most mothers pulled out the same snacks regardless of location; goldfish-shaped crackers and cheerios seemed to be universally delightful to most of the children. Husbands were present at two of the interviews, and were actively participating in watching over and tending to the children.

All of the women were very forthcoming about their childbirth experiences. Almost without exception the interviewer was asked about her own childbirth experiences, and when told that the interviewer was childless, they were careful to explain things that might be foreign to someone who had not been through childbirth. All of the women seemed very comfortable talking about the various aspects of their experiences, which may have been influenced by the fact that the interviewer was also female. One-half of the women expressed an interest in what the other women had said or experienced. Because obstetricians attend the vast majority of deliveries in the area, there was a keen interest in hearing about other women who had made the same decisions.

The interviewer succeeded in contacting all of the women for the second interview. Two women who moved between the first and second interviews and one woman who moved after the second interview contacted the interviewer with their new contact information, and several women emailed the interviewer during the following months after the interview to see how the research was going and to offer encouragement during the writing process. Overall, these women were open, friendly, and interested in the topic of midwifery, making the interviewing process a very engaging and rewarding process for both them and the interviewer.

The Interviews

Discovering Midwives

Since midwives only attend approximately 10 to 11% of births nationally and just under 15% of births in the state in which the women resided, it seemed relevant to ask the women how they had become aware of midwifery as an option. While two women could not recall how they first learned about midwives (having a sense they had "always known about midwives"), the others were able to recall how they first learned that there was an alternative to obstetrician-attended deliveries. Generally speaking, there were four key sources through which they learned about the midwifery option; from their medical practice, their insurance company, other women, or the media (particularly television and magazines).

The main way that women learned about midwives was through their OB-GYN practices. In some practices that have both obstetricians and midwives, the women were asked, upon confirming their pregnancy, whether they wanted to see obstetricians or midwives for their pregnancy and delivery care. It was at this point that over one-third of the women first became aware that midwives were an option. Brooke, a mother of three who had used an obstetrician for her first delivery, described a typical experience for women who first learned about midwives in this way:

> Brooke: The main thing was when I had my second child the practice had midwives. When I had my first, when I had my son, they didn't have any midwives. They had like six doctors and they added midwives. So when you rotated, as you saw the doctors, they rotated in the midwives. So I didn't know a whole lot about it, but I thought, well, you know, I'll try.

Three women found out about the midwifery option from their insurance company. All of these women were in the position of having to choose an OB-GYN practice because they were either planning to become pregnant or were already pregnant. One had never been to an OB-GYN practice, having seen her primary care physician for her women's healthcare needs, while another had a regular gynecologist who did not practice obstetrics. One woman who had recently moved to the state had not yet found a new practice to replace the one she had left. All three women learned about midwifery from their insurance company because their insurance coverage specified which local OB-GYN practices their policy covered. The lists of practitioners who participated in their insurance plan indicated how many doctors and midwives were in the practice, thus informing the women of insurance-approved midwives.

Another three women who learned about midwifery through the media cited television shows such as The Learning Channel's (TLC) "A Baby Story" or articles in women's magazines as their first exposure to midwifery-assisted delivery. The remainder of the women learned about midwifery from other women. One woman had grown up hearing about the midwife who had assisted in bringing her into the world through a homebirth. She was taught by her mother that midwives were the best, most natural, and healthiest option for delivering a baby. Other women (nine) learned through the experiences of their sisters and friends. All of these women described the positive terms in which these women related their labor and delivery experiences as leaving a major impression of midwives. Sondra told of hearing positive descriptions of midwifery experiences from friends:

> Sondra: They [her friends] were very happy with the practice that they used and they said they got more attention from the midwives when they went in, had longer visits, and more questions got answered. So when I asked, you know, recommendations when I

thought I was pregnant I wanted to make sure there was at least one midwife in the practice.

Once the women became aware of the existence of midwives, the majority (23) did additional research to get a better sense of what midwifery is and how it rated in terms of standard of care. While some (7) women took the endorsement of their OB-GYN or insurer as sufficient evidence of their competence, the remaining women investigated further. Some practices provided literature to their patients outlining the differences and similarities between obstetricians and midwives or gave them books such as *What to Expect When You're Expecting* (Eisenberg et al., 1996) that includes a very brief section on midwifery. Others started paying particular attention to information about midwives in the media, giving more attention to shows or articles including midwives than they had previously.

All of the women, though, gained additional information about midwives through their first visit with a midwife. Women described similar experiences during their first meeting with a midwife. Upon learning that a woman was not familiar with midwifery, the midwife explained how they were similar to and different from obstetricians, what their credentials were, and the situations in which they would no longer be able to attend a pregnancy or delivery (for example, if a cesarean-section was needed). Cassandra described a typical first visit with a midwife:

Cassandra: When I actually went to that appointment it was the best appointment I had ever had.

Interviewer: Oh, really?

Cassandra: Yeah. And she took up so much time with me. She was in there for like a half-hour versus the doctor, five minutes, "okay, you're okay, see you in four weeks." So I asked her if I could continue seeing her or what I needed to do. And she said, "well, go

ahead and see the doctor your next visit and just let him know that you're interested in having a midwife." So that's what I did.

Goals for Labor and Delivery

When the interviewees discussed why they decided to use a midwife for their prenatal, labor and delivery, and postnatal care, they brought up several goals consistently. One such goal, which two-thirds of the women mentioned, was a desire to attempt natural delivery or at least minimize the use of interventions. The term "attempt" is used because all of the women acknowledged that there were situations in which natural labor would have to be discontinued and interventions would be needed for the health and safety of the mother and/or baby. When describing their desire for a natural labor, the women meant that they wanted to avoid things such as the use of drugs/anesthesia and epidurals. Though it is more common than not that women use these interventions during labor in the United States, the women in this study who wanted to attempt natural labor felt that they were minimizing the risks to their babies. Several of the women (5) cited studies about babies who were exposed to drugs during labor and later had difficulties nursing.

Another primary motivation for using a midwife was a desire to avoid the use of medical instruments (such as forceps and vacuum extractors) and non-emergency surgical intervention (such as episiotomies and caesarean-sections) to the extent possible. This was true for all of the women who wanted to attempt natural labor (8), as well as many of the women who did not oppose epidurals or other medical methods of pain relief (10). Most of the women were aware that midwives are far less likely to intervene during labor and delivery, learning this either through their own research or through discussions with their midwives. Their desire for natural labor was motivated primarily by a belief that the fewer interventions that a baby is exposed to

during labor and delivery, the healthier the baby. Pam, who had a three year old and a ten month old, felt that the unnecessary and reckless use of forceps had injured her daughter during her first delivery experience:

> Pam: Oh, it was horrible. Well, it was my first baby so you go in and you're all excited, you want to hear, you know, you want the doctor to talk to you more. All they did was take out a measuring tape, put it over my belly say, "you're fine, okay see you next time." You know and I'd have questions but he was kind of condescending and the birth experience was horrible. I went in and she had, the baby had the cord around her neck so when I'd push the heartbeat would go down so all of a sudden they [said I needed] a c-section because they were afraid if I kept pushing I'd strangle her. They didn't know the reason, it was deceleration I think they call it. They didn't know the reason at the time but they said "okay, we're gonna do a c-section." So he waltzes in, he [hasn't been there], you know it's been the nurses the whole time. He comes in right when the baby is supposed to come out which is completely different than the midwife, she was there the whole time. And he goes "well, I could take the baby out now." Doesn't really let me think about it he goes "give me forceps." So I'm in la-la land, I didn't know what was going on. He gives me a cut, episiotomy, fourth degree which was all the way up to my neck pretty much. And puts these forceps in and of course doesn't realize that she's sunny side up. Her head's supposed to be down and it's up so the forceps then are going over her face so she has a scar on her head. And he yanks her out, so I am cut wide open, the baby looks like hell because she's got this huge forceps mark and he was just... And then he was like, afterwards, "oh, that was a tough birth!" I think he just didn't want to be sued. And then I find out later he sews me up and the doctor, the nurses, I guess they

need the room so they're trying to get me out of bed. I am in so much pain I can't even move. My husband had to help me out of the bed into the wheelchair and I'm out of it. It was horrible. Then he tells me I might not have normal bowel function because of the cut that he gave me which, luckily I do but…I mean to hear that I'm gonna be in diapers when I'm thirty-five! It was just... it was bad and on the phone he was like pretending it was such a horrible... you know, like he saved the day when I think he just didn't want to get his butt sued because my daughter had this gash in her forehead. It was just a bad experience.

The desire to avoid interventions also was related to their own health. Several women who had bad experiences with surgical interventions felt that they also were safeguarding their own health and well-being by using a midwife. Reba described her traumatic experience after giving birth to her second child:

Reba: Well, it was the third of July. It was late at night. He had plans the next day and that's, you know, he. That, she was born at 11:46 p.m. and he came in and he told them, told the nurses, "look if her water doesn't break send her home because I've got plans," and I'm in the room I can hear him outside the door. And a little bit later my water broke and they went and told him and she came back and said "he's not real happy about this." and "I'm so sorry," you know. He came in and said, "move her to delivery." And the nurse said, "well, she's only at 6 centimeters," and he said, "I said move her." So they moved me to the delivery room, and the nurses came in and they said "what are you gonna do?" and he said, "I'm finished" and the next thing I knew he had done an episiotomy. I never pushed. He just reached in and pulled her out you know. The nurse left the room because she just couldn't [watch]. And he's stitching me up and I was

> crying to [my husband]. And he was, he was laying across me on the table and he had his forearm on my chest and using the bars to hold me down because I had not had anything and this guy is stitching me up. With nothing! I'm crying and I was like, I finally cried out, "we treated our cows better on the farm! I've not had anything!" And he said, "what do you mean you haven't had anything?" and [my husband] turned to him and said, "she hasn't had any kind of pain anything." And he was like, "Oh. Well, I'm almost done." You know so it was just…. The nurse came in and said "I'm so sorry." And I said "it was not your fault." And she said "I'm sorry I had to leave. I couldn't watch." He had plans and we were an interruption. He was having a bad day.

Desired Characteristics in Birth Attendants

In addition to having specific desires for labor and delivery, all of the women, without exception, brought up characteristics of the midwives themselves as playing a part in their motivation to use midwifery services. Some of these characteristics were under the control of the birth attendant (personal behavior) while others were not (gender). The following characteristics were the most important to the women interviewed for this study.

Gender. About two-thirds of the women mentioned that knowing that almost all midwives are women did play at least a small part in their decision-making process. The desire to have a female birth attendant also had played a role in the decision-making process for women who had previously selected an obstetrician. This desire for a female birth attendant, whether it be a midwife or an obstetrician, was motivated by two specific issues. One was that in such a physically vulnerable and personal situation, they were more comfortable with a woman than a man. Mindy, who had her first and only child with a midwife, explained:

Mindy: For this particular specialty I would say I would prefer a female and as it ended up I'm glad it really was a female because I ended up having a lot of different fertility tests and, you know, I had a lot of different exams and you just feel more comfortable. I just feel more comfortable with a female and to me they are a little more caring and listen a little better I think. Or they pick up on things or I just think they listen more. And they do seem like they have - I just think they pay attention a little bit more than males do. Not to say male doctors aren't as good, but for this area I really wanted a female practice.

The other motivation was one of sympathy/empathy for what the laboring woman was going through. Many women felt that even if their female birth attendant had not given birth herself, she would still be better able to understand what it was like to go through labor. Karen expressed a sentiment heard from many of the women when she said:

Karen: Talking with my sisters, I knew that using a midwife I thought that maybe I could build a relationship and it was also a woman. I was big on wanting to have a female practitioner so I go to a group that has only women. Doctors and midwives. I just wanted to be cared for by a woman that maybe had some idea of what it was like to have a menstrual period and to have cramps and to maybe deliver babies if they delivered a baby…women had babies for thousands of years and they have done it even without having a doctor or by having other women to tend to them. And that's why I chose to have a midwife.

Of the women who had previously used OB's (13), more than half had chosen a female OB specifically because she was a woman. When asked if they found their female OB to be especially sympathetic, most of them (4) said that they were a bit more sympathetic than a male

OB, but not nearly as compassionate as a midwife. Kelly, who had two children, described her impression of doctors and midwives:

> Kelly: Midwifes always seemed, they were very personable. That was a little bit of a difference. Always very thorough and experienced. So that plus a little more personable with me, a little more…. Well, at that point you need a little bit of TLC, you know, for the ones who are getting later on into the pregnancy. The female doctor, she was very nice, very intelligent, but you know, just much more to the point. I'm sure she was busy and that's fine. The male doctor, oh, he was nice. He's younger, I think that was part of it. I'm going to attribute some of his lack of bedside manner to his youth. I think he's younger than me so. And that was part of what that was.
>
> Interviewer: So what was his lack of bedside manner?
>
> Kelly: Oh, well he was just, I had to deal with a lot of, I have mentioned I had pap smear problems. I had a biopsy and a couple of repeat pap smears and then a biopsy result.... he just wasn't real... seemed to forget. I mean, I was twenty weeks and back on the table. In other words, it's not easy for you to sit up on your own. And he didn't help me. I was sitting there struggling trying to get up and no, no woman number one, or a midwife who had already been through it, would have ever let me try to struggle and it just wasn't... I mean, it's not fun to go through a biopsy period, but when you're pregnant, it's really not fun. And so, I think that I really could have benefited from just a little bit more, maybe a little more talking, empathy, but then also knowledge that, well, when you're pregnant, you can't sit up on your own. That kind of thing. I mean I was really surprised that he wasn't aware of that.

Competency. Another very important aspect that the women were looking for in their birth attendant was competency. For low-risk pregnancies, these women felt that, at a minimum, midwives were at least as competent as obstetricians. Additionally, there were some women (8) who felt that midwives were in some ways actually more competent than obstetricians, since obstetricians typically are trained only in medical interventions for issues that arise during labor and delivery. In contrast, midwives are trained in both medical intervention and in non-medical/alternative practices that can decrease or eliminate the need for medical intervention during labor and delivery.

Quantity of Time. Other issues brought up by not all but a significant number of the women included the quantity of time that midwives spent with their patients, the quality of the time spent with patients, and the trustworthiness and truthfulness of their caregiver. Studies indicate that midwives spend more time per office visit with their patients than obstetricians (Farley, 2004; Office of Technology Assessment, 1986; Simkins, 1998). This difference also was reflected in the experiences of the women interviewed. Many of the women (7) who had used an obstetrician for earlier pregnancies compared their office visit experiences between obstetricians and midwives in much the same way that Diane, who had two children, and Cindy, who had seven children, did:

> Diane: And I think they took more time with me. They were more chatty, more on a personal level than a doctor-patient relationship like, you know, talking about your medical status and stuff like that. It was more just somebody coming in and talking to you like a friend and it was more personal, I think.
>
> Cindy: You know I'd say the biggest difference because I did notice a difference and the difference was more along the lines of the doctor was very “doctor-y,” I guess is really

the best way that I can think of it, very structured and, you know, this is how it's going to be. And the midwife was more along the lines of how would you, you know, here's what we're doing but how would you like to do this, you know, I want you to feel as comfortable as possible. And this is your child and I'm just here assisting you. So that's one thing that I really enjoyed about the midwife and that's why I went back after I had her for the first time, the next two times.

Other women described how using an obstetrician often meant more time was spent with nurses or other medical staff: Mary described the role of nurses in both of her pregnancies:

Mary: When I used a doctor the nurses spent more time with me than they did when I used the midwife since the midwife was spending more time with me, since they didn't need to be there as much. So, yeah, when I went through the doctor the nurses I rotated through because I was there a long time, long labors. They spent a lot of time with me which was nice. But with the midwife they more were just getting her -- having her check how far I was dilating and all those other issues, checking the monitors and things.

Quality of Time. The women also described a quality difference between what they typically experienced with obstetrician office visits and midwife office visits. Rossi described her office visits with an obstetrician during her first pregnancy as feeling rushed and inhibiting her from asking questions.

Rossi: I feel rushed. I feel like I'm intruding and I feel like, you know, that I'm going to be chastised [for asking questions] and it's a terrible feeling.

Tamara succinctly described her impression of the obstetricians:

Tamara: Doctors seem to always have their hand on the doorknob when they're talking to you.

Trustworthiness. About one-quarter of the women specifically mentioned trust as an issue that they found very important when choosing a birth attendant. Lynn, who had switched from an obstetrician to a midwife during the eighth month of her first pregnancy, described part of the reason for the change:

> Lynn: I really learned my lesson that it's important to trust your caregiver cause that was the issue with the doctor. We didn't feel like if we went in that we would believe anything she said. We didn't believe that she would take to heart what decisions we wanted to be made on our behalf if it came down to a really complicated delivery. And the midwife we felt understood, had seen it happen before, many, many times, and would advocate in a way that would benefit us.

Participation in labor and delivery. The main characteristic of a midwife-assisted labor and delivery expressed by all but one woman was that midwives spend a significant amount of time with laboring women. The women described how their midwives were there during even the early stages of labor, offering assistance in decision-making (such as whether or not to use pain-relief interventions or to try an alternative option), describing how things might progress, or providing support to their husbands. Cindy's comments capture the essence of what was described during the interviews:

> Cindy: She suggested, you know, you could go into the bathtub which I never had that one suggested before. With the doctors I remember the thing that I dreaded the most was having to be strapped down to the table for them to monitor the baby and I understand that's a process that you have to do that because they need to check on the baby. But with the midwife she said, "okay, just let me get the measuring, you know, make sure the baby's doing all right and then I'll let you get back up again and move

around" because it's a lot easier when you're not laying down straight to have to deal with the contractions.

The one woman who was dissatisfied with her midwifery experience described a situation similar to the ones women who had been dissatisfied with obstetricians had described. Generally speaking she found that her midwife spent little time with her, did not have a caring demeanor, and did not get along well with the nursing staff. Wendy, who had two children, described her experience during the interview.

Wendy: She was the one [midwife] I did not want to deliver and I ended up with her. Yeah, I just never cared for her and she was not good at all.

I: In what way?

Wendy: Well, she ended up getting in an argument with the nurse while I'm pushing and delivering about something. The nurse wasn't doing something right and they ended up arguing back and forth. She was just a very impatient and she stood, you know, down at the end of the bed like this with her arms crossed. Like waiting around--like it was really inconvenient to her and just…Everybody in the room saw her and mannerisms, it wasn't just me. And she did really nothing to comfort me or soothe me or anything, you know. Kind of got really snotty when I would ask questions, you know, with her remarks and stuff so I didn't - just she wasn't that great. She wasn't. I don't think she cared.

I: Oh, really?

Wendy: She was like - She disappeared for like, I don't know, four or five hours and my - she was not coming. I was not dilating. I was stuck at like, I don't know like four centimeters, I don't know, something like that for quite a while. And she had disappeared, she was gone, we hadn't seen her for a while and then finally she showed up

and she checked me and she said well let me try to, you know, break your bag a little bit because it was already broken but a little bit more because there was some fluid down by my cervix. But it was, I guess the sack must have been ripped up top. So it was just kind of dripping out where as if it had ripped by the cervix it would have came gushing out. So she just, you know, took her two seconds ripped it open a little more, came out and I dilated to nine in like twenty minutes. So had she done that like hours ago or checked me hours before that I could have, you know, done it so much sooner.

I: Oh.

Wendy: So it kind of ticked me off a little bit too.

Information Sources

When the women wanted information about pregnancy, labor, and delivery in general, or about midwives specifically, they turned to a variety of information sources. All of the women stated that they did a lot of reading during their first pregnancies. For the women who were happy and satisfied with their first labor and delivery (13), second pregnancies prompted much less research and information seeking. However, the women who were dissatisfied with their first experience (8) typically undertook another significant round of information seeking.

Printed Materials, Television, and the Internet

All of the women mentioned reading books and magazines during their first pregnancy. Two-thirds of the women specifically mentioned the book *What to Expect When You're Expecting* (Murkoff, Eisenberg, & Hathaway, 2002) when discussing the things they had read during pregnancy. In fact, two women stated that after verifying their pregnancies, the health practice actually gave them copies of the book with the other literature given to expectant mothers at their first visit. Opinions were mixed about this book, with approximately one-third

of the women finding it helpful, about one-third finding it useful for a few things, and the remaining one-third not really liking it. Other commonly mentioned books were *Husband-Coached Childbirth: The Bradley Method of Natural Childbirth* (Bradley & Montagu, 1996) and *The Birth Book* (Sears & Sears, 1994). All but three of the women reported receiving a packet of information from their practice during their first visit. For some of the women this was a relatively informal collection of pamphlets and coupons, while for others it was a well-organized notebook with a multitude of handouts, brochures, and record keeping pages. Some of these pamphlets were distributed by product manufacturers (such as baby formula companies), some had been written by the practice, and some came from area hospitals. Generally speaking, the women found the pamphlets put out by product manufacturers to be the least helpful.

Other Women

All of the women also found other women who had given birth to be significant sources of information. There was a sense among the women that the only certain way to get truth about some aspects of pregnancy, labor, and delivery was to talk to someone who had actually been through it. Pam, a mother of two, put it well when she said:

> Pam: Who else are you going trust better than your friends? I mean, they know you already so they know your likes and dislikes. They know you're not strange, you know. That's the number one reason, even with my bad experience, I still would have…. My number one reason for going with a midwife was my friend's recommendation.

Classes

All but two of the women had taken some type of childbirth preparation course, at least with their first pregnancy. Most courses were non-specific regarding method (i.e., they were not specifically "Lamaze" or "Bradley" classes), but incorporated general breathing techniques and

discussions of pain management interventions (such as drugs or epidurals). Most of these classes were offered by the hospital and also gave information regarding hospital policies (i.e., what they would and would not be allowed to do or have). About one-half of the women found that the labor and delivery information was not particularly helpful because they already had found that information long before taking the class. Tammy described her experience which was similar to those of other women in the study who did not find their class useful:

> Tammy: I don't know if you just call it a childbirth class or I guess it's like they give you all these different ideas to do while you're in labor, stuff like that, you know, none of which I really used. A waste of time.

Only one woman took an official Lamaze course, though Lamaze-type techniques (such as panting) were the most commonly presented in the birth classes the hospitals offered. Four women took Bradley method courses. Women who used the Bradley method spent more hours in class and covered a larger range of information, including nutrition during pregnancy and baby care. There is a theme of patient education and empowerment running through the Bradley method teachings, which promotes asking questions and investigating alternatives. For women who embraced the Bradley method, they found it to be a great source of information and support, though it was not always warmly embraced by hospital staff. Lynn described how hospital staff reacted upon hearing that she was a follower of the Bradley method:

> Lynn: Bradley typically has, somewhat well deserved, a reputation at hospitals of "oh, no, there's the Bradley, who wants the Bradley couple?" And the people who are into unmedicated childbirth run to the room and the people who can't stand having to argue with people who have thought things through roll their eyes. Bradley does a really good job of explaining, informing, giving you resources so you can make your own decisions.

You feel defensive because you know they're going to come at you with [prejudice toward this method].

Hospital Tours

With the exception of the two women who had given birth at home exclusively, and one other woman, all of the women had taken a tour of the hospital before giving birth. The biggest benefits they reported to taking a tour were logistical, including finding out where to park, what entrance to use, which floor to go to, etc. While those may seem like small details, the women reported that when they were in the rush and excitement of getting to the hospital, it was very nice to know where to go and what to do at a time when they had many other things on their minds. Diane described its usefulness when she and her husband went to the hospital for the birth of their first child:

Diane: It was that I knew where to go. I mean, I think pretty much most of the hospitals have standard labor and delivery rooms now. But it was nice when I walked in that I knew to go to the elevator to go up to X floor, especially with my daughter because my second labor I almost had her in the car. By the time I got up to the room I was nine centimeters. By the time they managed to get me to lay down I was in the hospital for twenty minutes before I had her. So if I had had gotten lost the second time I'd have been in trouble. Luckily the first one didn't go quite so quickly, it was only like six hours. But, you know, the tour was helpful in that I knew where to go.

Convincing Others

Because these women were choosing a birth attendant not considered the "norm" in U.S. society, some of the women found that they had to justify their decision to others. About one-quarter of the respondents had to explain and/or convince spouses, family members, or friends

that their decision to use a midwife was sound. Commonly raised issues included the belief that midwives are not as skilled or knowledgeable in obstetrical medicine, or that, even if they were trained in obstetrics, they were adequate but not the "very best." This criticism sometimes resulted in the accusation of placing their "experience" ahead of the health of the baby. Other criticisms were more general, proposing that midwives, and the women who use them, are "hippies" or "granola-types." Lastly, many of these women noted that some people contended that midwives insist upon "natural" labor, not allowing the use of drugs or epidurals, which is not accurate of modern midwifery in the United States.

These questions and criticisms came from a variety of people, including husbands, other family members (such as parents and sisters), and other (non-related) women. There are many stereotypes about midwives and what they do. Pam described common misconceptions:

> Pam: I think midwives have that old thing [stereotype] but now because they're in doctor's practices you get all and you deliver in a hospital, you get all the same things offered by the doctors in the hospital. So you get the best of both worlds pretty much is what it is. You get a female, a woman who doesn't have the ego of some attending doctor, who probably gave birth before. They spend more time with you yet you still get an epidural, you still get to go to the hospital. It's the best of... it's perfect.

The women in the study dealt with these issues by trying to educate the questioner about midwifery. Some (4) women found that just separating fact from fiction was sufficient to calm the concerns of others. Stacy, who had two children, and Tamara, who had three children, described dealing with other people who expressed uncertainty about midwives:

> Stacy: People do ask me and when I tell them I used a midwife for some reason they immediately think I've had my babies at home. Because that's what they think of as a

midwife is a home delivery and so I have to correct them and say "no, this is, you know, it's just not a doctor." So, yeah, people have asked me.

Tamara: As far as the certified nurse midwife, no, there wasn't much of an issue there. I think that my family, probably my family probably asked a few questions and once they understood that this was part of an OB practice and that there were doctors there they had no problem with it.

Actual Birth Experiences

Previous Experiences (More than Three Years Ago)

Of the 13 women who had used obstetricians for previous births, they were relatively evenly divided between those who had negative experiences with an OB in the past, those who had not necessarily had a bad experience with an OB but felt it could be "more," and those who had good experiences with their OB's but had either heard good things about midwives from others or had their OB suggest that they try a midwife. Most women (17), even the ones who had bad experiences with OB's, expressed sympathy, or at least understanding, toward them given the fear of malpractice suits in our society. These women attributed OB's propensity toward use of interventions (forceps, vacuum extractors, cesarean-sections) as a result of their fear of being sued for malpractice or as a reaction to a lack of time to spend with each woman. A few women (4), however, did feel that they had suffered due to the explicitly misogynistic attitude of their doctor (and this applied to both male and female doctors).

Most Recent Experiences (Within the Past Three Years)

With the exception of the homebirth mothers, all of the women used medical practices that were made up of several obstetricians and several midwives. Most practices were not able to guarantee that a specific midwife would be available for their labor and delivery, though about

half of the women reported that they did get the midwife they most wanted. For practices with multiple midwives, most women either rotated among the midwives for their office visits, or met with each midwife at least once. The only women who were virtually assured of having a specific midwife in attendance at their labor and birth were the homebirth mothers.

Achieving Goals in Reality

What Helped and What Hindered

Many women mentioned obstacles that hospitals present to having their desired labor and birth experience. In addition to policies on electronic fetal monitoring and eating and drinking during labor, they also were critical of a number of other policies. These policies addressed issues of what was done with the baby after birth, such as whether or not babies could room in with the mother, whether the baby had to be taken out of the delivery room for bathing and weighing (even if the father could go), and tests, vaccines, and ointments routinely given to the newborn. Other policies affected women during labor such as whether or not the laboring woman was allowed to walk, shower, or sit in a tub during labor, the number of people allowed in the labor and delivery room, and whether or not the woman was required to have an IV or a heparin lock (a needle that is inserted in the back of the hand with a valve attachment that allows for quick insertion of an IV line without having to locate a vein). About one-quarter of the women expressed that what they preferred conflicted with hospital policy. Two-thirds of the women explicitly stated that they knew they had the legal right to refuse certain interventions and requirements (such as refusing vaccinations and ointments for the baby and leaving the hospital against medical advice) and that they also had the right to refuse to sign certain documents that would waive their right to consent. These women said that they learned about their rights as a patient in their childbirth classes (particularly those who either had used or had

become familiar with the Bradley Method), through their reading, or through their professional education (as the sample included one nurse, two doulas, and one scientist).

Birth Attendant Policies vs. Hospital Policies

It seems important to distinguish between birth attendants and hospitals in terms of policies and authority. About one-quarter of the women described situations in which they had been told one thing by their birth attendant (either midwife or obstetrician, but more typically obstetrician) and another by hospital staff. A common example of such a situation was when a woman was told by her birth attendant that she would not have to wear an electronic fetal monitor continuously during labor. The women who did not want to be on the monitor continuously all cited studies showing that continuous electronic fetal monitoring has no benefit over periodic monitoring or other forms of monitoring (such as a telemetry monitor). Despite these findings, some hospitals still require continuous monitoring, primarily to create a "paper trail" in the event that they are sued for malpractice (Murkoff, Eisenberg, & Hathaway, 2002). For women who had been in this type of situation, about one-half of them felt that their birth attendant did not advocate for them sufficiently. Midwives in these situations were more likely to challenge hospital policy or to attempt to circumvent it if feasible.

Homebirths

The homebirth mothers shared a significant characteristic. All of the mothers who had given birth at home (5) felt that they were able to have the birth experience they desired. Dawn, who had a hospital birth and then a homebirth with her next child explained her decision:

> Dawn: And, you know, one of the questions my midwife said "why do you want to do this?" And I said, "you know, I want to concentrate on having a baby and not fending off people who are trying to do things to me that I don't want done."

Specifically, all of the homebirth mothers were able to avoid medications and other medical interventions. They all were able to eat and drink as they felt appropriate, free to move about as they found comfortable, and able to have a quiet, stress-free environment for their births. All of the homebirth mothers in this sample were very satisfied with their experiences, felt that their babies were healthier for it, and would consider having a homebirth again. Additionally, all of the women spoke with a confidence that set them apart from the other women in the study. This confidence seemed to come from having made a plan and executed it, delivering well and healthy babies, and from gaining a sense of empowerment by being able to labor and deliver without relying on outside interventions. While many of the other women in the study also exuded a confidence about the decisions they had made, particularly the women who had given birth two or more times, the homebirth women were exceptionally confident in a way that had revealed itself in the other aspects of their lives. Reba, who had given birth to her youngest son at home, described the way in which her experience had empowered her in other ways:

> Reba: Because I'll tell you the power I felt after [my last baby] was born. That was the first time in my life that I ever felt I could achieve something. That I could do it, you know. I graduated first in my class in high school. I was about to graduate from [state engineering school] and giving birth to my first son was the first moment that I realized I had power. And then with [two of my older children], it was taken away because you realize that, you know, you recognize I have power and you go to the hospital. I'm the one that had to sign the paper saying I wasn't going to get a say. You know? And so I think as women, we are so taught and I don't believe it's all taught. You know I do believe that we were made to nurture and support those around us. But we're taught that part of nurturing and supporting those around us is giving them our power. And it's

really not. It's just the whole crystallization of that for me with [my homebirth]. It just brought it all together because I chose, I picked my support team. They supported me. I went through it, you know I was the only one going through that. They were, you know they were the fans on the sideline cheering. You know I was Michael Jordan with two seconds left and I'm at half court and it's a one point game and I made the shot. You know and that's just like, oh my God! You know it really is that empowering and yet, the only way I could ever be in that position is to have the midwife. You know when you go to the hospital and you're putting their…you know you're the bystander. The laboring mother is in the stands. Hoping, you know, and everybody else is on the court. Well, she's the player, and she's really not in, in the settings that we have created, she's really not. But if you take that and you extrapolate it out to your life, you know. It's like that in the boardroom. It's like that in the office. It's like that at school. You know women really have created, participated in the creation because we've all. But as a society we've created this place where we don't always put the best players on the court. A lot of times our best players, the ones that can affect the outcome, are the ones we put to the side. Because it's just kind of how it happens and it's just been really. It really changed the way I am at work now. Because so many times I knew I had the answer, but I wasn't the person that traditionally would be the one that should have the answer so. I would try to get the answer out there, but I wouldn't stand up and say, I've got the answer, here it is. Because that wasn't my role, because roles are very important and the things that I've achieved at work in the four months since [the baby] was born. Everybody is like, "my God this is different." And it's not that I was ever timid. Because if I had an opinion, boy back off. Watch out. But this was just, you know, when the answer wasn't critical or

you know, I would let the person who should have the answer. And now it's just like, "nope, no way, that's the answer." "Well, how do you know that?" "Well, I've just been there, done it, seen it, whatever. Figured it out. I know he should have it but this is really it." And it's just, you know, I just see a difference in me and the way things are changed.

Desire to Use Midwifery Services Again

Future (or Hypothetical) Births

When asked if they were to have another child if they would use a midwife again, all but one woman gave an emphatic "yes!" The one woman who answered no basically described a negative experience (such as going hours between times that her midwife checked in on her, leaving her alone without information or guidance, coming in just in time to "catch the baby") similar to the experiences that the other dissatisfied women had reported with obstetricians.

As mentioned before, the majority of women's health insurers (20) provided listings of the obstetrical practices covered by their policies. Sometimes highly recommended doctors/midwives did not appear on their list. However, all of the insured women (27) had midwife options for hospital births on their approved provider lists, especially for their most recent births. One woman did pay out-of-pocket for her midwife-attended birth at a hospital. In addition, none of the homebirths that occurred in the state in which the interviews took place were covered by insurance (despite the fact that midwife assisted hospital births were covered by their policies), thus requiring out-of-pocket payment. When the women whose midwife-attended births had been covered by insurance were asked, hypothetically, if they would pay out-of-pocket for a midwife if midwifery services were no longer covered by their health insurance, 13 women said they would be willing to make that financial sacrifice. Six women said it would be dependent on their financial circumstances at the time and the actual cost of the midwifery

services. Eleven women said they would not be willing to pay out-of-pocket if midwifery services were not covered by their health insurance.

Conclusion

The women who participated in this study shared their pregnancy and childbirth experiences. In particular they discussed how they made choices for their care and how well those choices worked for them, the babies they gave birth to, and their family as a whole. Chapter Five will discuss how these experiences can elucidate the consumer aspects of the maternity healthcare market, how this process might be modeled best, and why it is important to study this particular consumer healthcare issue.

CHAPTER FIVE

CONSUMER ISSUES IN CHOICE OF BIRTH ATTENDANT

The purpose of this study is to investigate consumer decision-making behavior in healthcare markets. The choice of a birth attendant (obstetrician or midwife) presents an excellent opportunity to study the details of a healthcare services decision because most women have at least several months to make and change plans, look for information, and many well-documented choices when it comes to childbirth preparation, methods of delivery, birthing environments, and attendants. In this study, the researcher focused on women who had chosen midwives to deliver their babies because they had made a choice that sets them apart from approximately 90% of other women in the United States. Interviewing women who had made a conscious decision to go against the status quo can help to ensure that a more explicit decision-making process took place, making it easier to distinguish the various aspects of that process. By determining what women are looking for from their healthcare service providers and what sources of information they found most useful, the healthcare industry, insurance companies, and policy makers will have a clearer sense of what women want. This research probes women about what they were looking for from their birth attendants, which hopefully can be part of a larger effort to explore what women are looking for from their healthcare providers.

Overview

The researcher interviewed 30 women who had used the services of a midwife within the past three years in the greater metropolitan area of a large southeastern city. The interviews focused on their experiences and the process of choosing a midwife as a birth attendant,

including information sources used. The majority of the women found out about the midwife option through their medical practice, insurance company, or other women who had used midwives themselves. All of the women reported reading as a primary source of information about pregnancy and midwives, especially for their first pregnancies. They also learned about midwives, their philosophies, and practices through face-to-face interactions with midwives. About one-fourth of the women expressed that they had to convince friends or family members that choosing a midwife-assisted labor and delivery was a safe and sound choice.

Two main motivations for using a midwife consistently surfaced during the interviews. One was a desire for a natural labor and delivery, or at least for the minimum number of interventions necessary for the health and safety of mother and baby. The other desire was for more attention and understanding/sympathy for the woman during pregnancy, labor, and delivery. The fact that the vast majority of midwives are women was appealing to at least half of the women in the study.

In terms of achieving the goals they had for labor and delivery, the women mentioned several things that helped or hindered. Having a support network during labor, whether it be husbands, sisters, friends, or doulas, seemed to help women through the process and to maintain (to the degree practical and safe) their stated desires for their labors and deliveries. Midwives generally were instrumental in this process, by negotiating with hospital staff, and/or spending significant periods of time with the laboring woman so they could make frequent suggestions and offer support and guidance. Opinions were mixed as to whether birth plans were useful in achieving goals for labor and delivery. Birth plans are written documents outlining what the woman wants for her labor and delivery experience, such as whether or not she wants to use drugs or epidurals for pain management or prefers non-medical pain management; who may

make decisions for her if she is incapacitated; whether or not she would prefer electronic fetal monitoring or another option; and a myriad of other issues important to the pregnant woman. Opinions also were mixed about the usefulness of childbirth preparation classes. The only women who were universally pleased with their classes and attributed their childbirth preparation method with helping them to achieve their goals were the women who had used the Bradley method. The women mentioned hospital policies as one of the primary obstacles to carrying out a birth plan or meeting goals for labor and delivery. The policies varied from hospital to hospital and included requirements for continuous (or nearly continuous) electronic fetal monitoring, time constraints on the number of hours a woman could spend in labor, and the availability of different pain management tools (such as epidurals, pain medications, and sterile water injections).

Despite near universal satisfaction with their midwives (the exception was one woman who had had a very poor experience with her midwife-assisted birth), financial considerations would be the ultimate determinant of the future birth attendant for the majority of the women. While health insurance covered the midwifery services of all but two of the women who used midwives in a hospital setting, when asked hypothetically if they would be willing to pay out-of-pocket if that were the only way they could use a midwife for a future pregnancy, only five women said they definitely would. Others said it would depend on the cost of the midwifery services and the household financial situation at that time. Because homebirths rarely are covered by insurance in the southeastern state in which the women lived, the homebirth mothers already had made the decision to pay out-of-pocket for the specific birth experience they desired.

During the first round of interviews and immediately thereafter, the data were analyzed without guidance by a specific theory. After the first round of interviews and analysis, however,

it became apparent that the Theory of Planned Behavior (Aizen, 1985) included many of the categories and themes that were present in the data. Therefore, the second round of interviews, which were conducted on the telephone, were guided somewhat by this theory as well as by consumer information search theory. This guidance meant that the questions asked during the telephone interviews were much more specific than the general questions that had been asked during the first round of in-person interviews (see Chapter Three for a discussion of the interview questions). The last round of data analysis, which came after the completion of coding for all of the in-person interviews and transcription of the telephone interviews, was conducted from a consumer perspective. Subsequently, the interviews were analyzed to see if they verified previous studies of consumer information search theory. Then the Theory of Planned Behavior was introduced to learn if the model properly captured the multifaceted nature of this decision-making environment.

This chapter will address specifically how traditional consumer studies theories apply to decision-making in this healthcare environment and how those theories might better fit within an alternate theory of behavior and intention modeling, the Theory of Planned Behavior. The relevance of studying decision-making in this healthcare environment and possible policy implications also will be discussed.

Applying Traditional Consumer Theories to Choice of Birth Attendant

Two consumer behavior theories in particular address aspects of the decision-making process that the women described during the interviews. The first is consumer information search theory, which addresses the information-seeking behavior of the women, i.e., how they found information, whom they trusted, and what information sources they found the most useful. The second consumer behavior theory involves issues of consumer/customer satisfaction as is

often studied in marketing-focused research on healthcare services. As there now are several well-documented options available to women for their pregnancy and childbirth experiences, women in the United States face a situation similar to other consumer environments where information and choices come into play in a way that is different than how healthcare markets traditionally have been conceptualized.

Consumer Information Search

Because insurance covered the midwifery services of most (23) of the women in this study, Stigler's model of consumer information search, in which price is the dependent variable, does not apply in a traditional sense. However, many consumer information studies have focused on other aspects of the information-seeking process. Many of the findings of these studies were supported by the experiences of the women interviewed for this research.

All of the women mentioned at least one of three main formal sources of information in their discussions of their experiences. All of the women turned to books, and two books in particular were mentioned frequently. Many of the women (22) mentioned *What to Expect When You're Expecting* (Eisenberg, Murkoff, & Hathaway, 1991) and/or *The Birth Book* (Sears & Sears, 1994). They used their books by reading them in entirety and/or using them as a reference to turn to as specific issues arose. Many women who had found a particular book they liked talked of turning to it time after time as they progressed from trimester to trimester or for guidance when doing things such as preparing a bag to take to the hospital with items for themselves and their newborns. Other studies have found that consumers can be overwhelmed by too much information (Jacoby et al., 1974). The way that many of the women in this study dealt with such an abundance of information was to settle eventually on one, or perhaps two, books to serve as a reference for most questions.

The women also turned to experts when they needed information. These experts included doctors, midwives, nurses, chiropractors, pharmacists, and lactation specialists. With the exception of one woman whose practice's careless record-keeping resulted in sometimes terribly insensitive responses[1], all of the women said that they were comfortable calling their practice whenever they had a question. The women reported that about half the time a midwife would return the call and the other half a nurse would return the call. For most questions the women were equally happy with either a midwife or a nurse calling back. The women also occasionally turned to organizations for expert advice. La Leche League, an organization that provides breastfeeding support and information, was cited most frequently.

Women also turned to more informal sources of information. The main source of informal or non-expert information was other women. These women included mothers, sisters, friends, co-workers, neighbors, and church members. While these women may be considered non-experts, the women who participated in this research had much regard for the experiences and opinions of other women. In some ways the women even trusted other women more than some experts. This applied to the experience of labor and childbirth, when at times some women felt that they would be told what they wanted to hear by doctors, as opposed to what would actually happen. These experiences support King and Haefner's (1988) findings that patients often consult friends and relatives when choosing a physician. In this study, the women also used these women for other types of information. These women often became, in a sense, human reference books, especially for first-time mothers.

[1] This participant had lost a pregnancy in the first trimester as documented in her file after she visited her midwife. The next day another midwife/nurse called to give her lab results from blood work done earlier in the week and said "everything looks fine!" which seemed to indicate that her chart had not been consulted. The participant was very upset by this call, and said that it had not been the first time they had been careless in record-keeping.

One last, but very important, source of information for the women was their comfort level with their caregiver. Many of the women (22) told of immediately feeling comfortable with a midwife, or of "hitting it off" with the midwives they met, in a way that most of the women who previously had seen obstetricians (8) said they had never really felt with a doctor. Often times it was this interpersonal connection that firmly convinced the women that they had found the right birth attendant. Other times the feeling related to willingness to talk about the physical state of the pregnancy, labor, or delivery. The interpersonal connection went beyond just warm feelings, because the women expressed that when they were more comfortable with their service provider, it was easier to express concerns and ask questions.

There were times when the women used proxies for information that was missing or would have been difficult to find. Over half of the women (16) said that the fact that midwives are almost always female played a significant role in their decision to select midwifery care. In this case, the women were using gender as a proxy for missing information regarding the demeanor of their childbirth attendant. Among the women who stated a preference for a female, there was an assumption that a woman would be more sympathetic, especially if she herself had gone through pregnancy and childbirth. There was even a sense that a woman who had not given birth still would be more sympathetic than a man who had never experienced menstrual cramps or gone through the experience of a pelvic examination and the issues that can accompany that experience.

Another factor that at times was used as a proxy for missing information regarding demeanor and bedside manner was professional credentials. For women who were familiar with midwifery training or had opinions about the patriarchal nature of traditional medical training, the midwifery credential represented a different attitude toward pregnancy and childbirth.

Midwives are trained that pregnancy and childbirth are natural processes, rather than conditions requiring treatment. This attitude translated into what was perceived as a more positive attitude on the part of midwives. One woman summed up her experience by saying that for a first pregnancy, there is a particular excitement involved in having a baby that was echoed by her midwife while the doctor she had used previously never showed any enthusiasm or particular interest. There was also an assumption that midwives had less of a profit motive, which a few of the women (4), and particularly the homebirth mothers, felt might be behind the high number of interventive methods used in childbirth in the United States. Lastly, the women felt that as traditionally educated doctors, obstetricians were trained to "treat" patients, which created an impression that they were motivated to use interventions and drugs in a way that midwives were not. Traditionally, midwives are trained to be patient until intervention is truly necessary.

Consumer/Customer Satisfaction

The women in this study were most satisfied with their choices when they achieved their goal (or goals), or at least felt that their service provider had tried their best to help them have the labor and birth experience they desired. The women's goal to minimize the number of technological interventions during labor and delivery demonstrated that they wanted to exert a certain amount of control over their situations, either by being able to make the decisions or at least by being consulted as an integral part of the decision-making process. These findings reinforce those of Howell-White (1999) and Galotti et al. (2000), who found that women who chose midwives wanted to make decisions regarding which medical interventions would be used.

For many of the women in this study (15), the demeanor of their birth attendant was of utmost importance. They described their ideal caregiver as sensitive, patient, friendly, sympathetic or at least empathetic, and kind. These same basic characteristics also were found to

be highly correlated with consumer/patient satisfaction in studies by Pelteir et al. (2000) and Halliday and Hogarth-Scott (2000).

With the exception of one woman who had a very negative experience with her midwife, the other women in the study all were quite satisfied with their midwifery experiences. They indicated that if they had another pregnancy (whether having another child was their intention or just in a hypothetical sense) they definitely would use a midwife again. Their intentions indicated a high level of satisfaction and customer loyalty, if not to a specific midwife, to midwives in general. Given that the most common reason for hospital admittances in the United States is childbirth, this is an important finding because one of the main aims of marketing obstetrical services is to create repeat customers.

Issues Not Fully Developed in Traditional Consumer Theories

The theories used in traditional consumer studies frequently do not address several issues that the women raised during the course of their interviews. These issues include the social environment and lack of complete control over the birth process and its outcome. These issues reflect the complex environment in which healthcare consumers now are making decisions.

An issue that had an impact on the decision-making process was the opinions of significant others. The desire for approval from these other people also was at times a desire to avoid conflict and confrontation. Issues of approval and conflict avoidance often seemed to arise when attempting to justify to friends and family members (including husbands) the desire to use a midwife instead of an obstetrician. Several women (4) discussed how they were somewhat interested in using a midwife during their first pregnancies, but were dissuaded from doing so by nervous and/or reluctant husbands or parents. These significant others who had reservations about midwifery typically believed that M.D's were "better" or more qualified at pregnancy and

childbirth care than midwives who were perceived to have less training. These opinions often were based on incorrect information from outdated stereotypes of midwives. In particular, there seemed to be a lack of understanding of the training that midwives now receive, especially given that the women interviewed had used certified nurse-midwives who have received both traditional nursing training (typically with a registered nurse status) and then extra training and interning beyond the bachelors degree through midwifery training. The nervousness and accompanying reluctance to use a midwife on the part of the significant others may be reflective of the credence properties of maternity/obstetrical services. Ostrom and Iacobucci (1995) found that consumers were more price sensitive for experience goods and more quality sensitive for credence goods. When confronted with a situation in which the outcome is one's child, the uncertainty associated with credence goods is compounded by the extraordinary value placed on a positive outcome (i.e., a healthy baby), making consumers in this market especially sensitive to quality issues, real or perceived.

The desire to have one's baby delivered by a midwife is not a decision that one can make and be completely assured that will be the ultimate outcome. All of the women acknowledged that labor and delivery are situations that can be unpredictable and recognized that circumstances can arise that require, for the health and safety of mother and baby, intervention requiring an obstetrician. This was the primary reason women who did not have written birth plans gave for not putting their desires in writing because, as one women described, birth plans can "go straight out the window" once labor begins. Another determinant of control includes the financial ability to choose between a midwife and an obstetrician. The health insurance of most women interviewed covered midwifery care for hospital births (26), but when asked if they would be willing to pay out-of-pocket for midwifery services if they were no longer covered, the majority

said that either they would not be willing to dip into their own financial resources to pay or that it would depend upon their family's financial situation at that time. While six of the women who participated in this research already had been in situations in which they had to pay for their midwifery services without the assistance of health insurance (either because they did not have insurance or because of the parameters of their coverage, such as not covering midwife-attended homebirths), many of the remaining women, even the ones who had been very satisfied with their midwifery experience, said that in the end, financial considerations could outweigh the desire for a midwife.

Theory of Planned Behavior

As just discussed, several traditional consumer theories may apply to the decision-making process of choosing a birth attendant. However, they do not capture some of the unique factors in this consumer decision-making situation, such as lack of control over the actual outcome and the impact of the social environment. The Theory of Planned Behavior provides a potentially valuable method of modeling consumer behavior in environments that contain an aspect of uncertainty.

The Model

As discussed in Chapter Two, the Theory of Planned Behavior looks at three main areas that in turn impact the intention to perform a specific behavior. The three areas believed to influence intention are beliefs, subjective norms, and control beliefs. Then the degree to which an individual actually has control over the environment in which the intention would be carried out is introduced before determining whether the behavior was carried out successfully. The issues the women discussed in the interviews seemed to fit well into these categories, while including the uncertainty factor that is involved in labor and delivery outcomes. The following

discussion elucidates how the Theory of Planned Behavior can be applied to the decision-making process and resulting behavior in this environment.

Intention. What became apparent during the interviewing process was that the intended behavior the women were most concerned with was not using a midwife specifically, but rather having a specific experience in their labor and delivery. The women all had one or both of the following goals (intended behavior):

1. A labor and delivery with the fewest medical interventions (such as pain medications, epidurals, labor-stimulating drugs, episiotomies, forceps and/or vacuum delivery, and cesarean-sections) as possible, as long as the health of the mother and/or baby was not jeopardized.
2. An experience of prenatal care, labor, and delivery attended by a professional with a sympathetic/empathetic disposition who would be sensitive to their needs and desires.

Therefore the factors in the model are working toward one or both of these goals. Because each woman also specifically mentioned that she wanted to deliver a safe and healthy baby, this was a constant for all of the women interviewed and is included as an assumed part of both of the women's goals for their labor and delivery experience.

Behavioral Beliefs. For the women who desired the fewest interventions possible, these beliefs included concern about the safety of interventions. For example, the women were concerned that instruments such as forceps and vacuum extractors could cause physical damage to the baby or themselves. Many women (6) also expressed concern that drugs they take during labor also would affect the baby, causing the child to be sedated after birth. The women believed that babies who are sedated are less able to latch on and successfully breastfeed immediately after birth, which is important for the health benefits of breast milk and to bond with their

mother. A few of the women (4) also were concerned about the potential dangers of epidural anesthesia, including painful recovery as the drugs introduced into the spine wear off and the small but consequential risk of paralysis or death. Several women (4) were concerned that use of an epidural could slow down labor, which potentially could cause a stall in labor significant enough to require additional interventions such as cesarean-sections. Several of the women (6) also were concerned about the use of labor-stimulating drugs, which can cause an increase in the intensity and speed of contractions, leading to an even more painful unmedicated labor and delivery or the necessity to take pain-reducing measures. A few of the women (4) questioned the motives of doctors who use these interventions, believing that some doctors rely on interventions to keep them on schedule or to increase their profits.

The women also desired a more personal or sensitive caregiver for their prenatal, labor, and delivery care. These beliefs concerned the dispositions of various types of birth attendants and the potential differences between male and female caregivers. Many of the women (12) stated that their decision to use a midwife was based upon a belief about the type of care given by obstetricians. They believed that obstetricians tended to be more rushed, which not only led them to have shorter appointments in the office, but also to spend far less time with them in the hospital, typically only showing up for the delivery, with little or no time spent with the laboring mother. They also believed that a traditional medical school education trained obstetricians to view pregnancy and childbirth as an illness, causing them to believe that medical interventions were necessary more often than not. They believed that doctors were not trained to be sensitive to the total well-being of pregnant women, focusing on the physical aspects of pregnancy to the detriment of the mental and emotional well-being of the woman. Lastly, there was a belief that doctors tended to be more authoritarian, which limited their desire to communicate with and

involve the woman in the decision-making process, even in non-emergency situations when there was time for explanation and discussion of what was going to be done.

In terms of their midwifery beliefs, they believed that midwives were trained to see pregnancy as a natural process, making them more patient and less likely to use medical interventions in non-emergency situations. They also believed that midwives had a broader knowledge of alternative methods in areas such as pain management, various positions to try to facilitate delivery, and methods to get a baby to change positions in utero if it is not properly positioned for delivery (such as a breech position). They also believed that midwives are less motivated by profit, which makes them more inclined to spend more time with women during office visits and during labor and delivery. Lastly, there was a belief that women (whether they were doctors or midwives) were more likely to be sympathetic to the issues pregnant women face (if they themselves had given birth) or at least empathetic (by virtue of having experienced a menstrual cycle). There was also a perception that women were "better listeners" than men. Because the vast majority of midwives are women (and indeed, no one had ever met or used a male midwife, though it was rumored that there was a male midwife in practice in this city), the beliefs about midwives and female practitioners overlapped somewhat.

As discussed in Chapter Four, the women in the study turned to a variety of information sources to develop these beliefs. The sources included books, physicians, midwives, nurses, other women, the Internet, and television. Their beliefs also were based on past experiences, particularly for women who had more than one birth experience. Some women who did not have previous birth experience still used previous medical experiences as a reference, particularly when it came to beliefs about the typical demeanor of doctors or differences in care based on gender of the caregiver.

Attitude Toward Behavior. Positive attitudes toward midwives, with the exception of one woman who had a negative experience with her midwife and midwifery practice, were a constant for the group, but attitudes toward obstetricians varied. The women's attitudes toward behavior also were affected by the strength of their beliefs that had been affected by things such as their specific education and training. Those women who had training in nursing or another medical field tended to have strong beliefs (for example, about the consequences of using forceps and vacuum extractors during delivery or the use of drugs during labor) given their confidence to understand the science behind the medicine. For other women, their attitude toward one of the goals ("behavior" in the model) was based on the perceived positive or negative consequences. Some women (2), for example, who believed that pain medications used during labor can sedate a newborn, did not think it was ultimately consequential, while other women (4) had very strong beliefs that it could have serious and potentially long-lasting consequences.

Normative Beliefs. Normative beliefs are what the women perceived to be the beliefs of people around them. The most significant people were husbands, mothers (and to a lesser extent both parents together), sisters, friends, co-workers, neighbors, and medical professionals. Almost all of the women (27) explicitly acknowledged the existence of normative beliefs. Sometimes normative beliefs matched their own behavioral beliefs, while at other times they contradicted each other. When there were contradictions, they were based either in misinformation regarding midwives (such as that they force women to go through unmedicated childbirths or that they are not medically trained) or in stereotypes of midwives and the women who use them ("granolas," "hippies"). Some women (4) actively tried to change these normative beliefs by discussing them, providing evidence to the contrary (such as books and articles), or

having the significant other meet a midwife. Other women (2) simply stopped discussing the issue of midwifery with those significant others who held contradictory opinions.

Another issue related to the conceptualization of the Theory of Planned Behavior model is that, for this particular healthcare situation, there can be a significant amount of overlap between behavioral beliefs and normative beliefs. Specifically, the views and experiences of other women seemed to fall into both categories. The women interviewed frequently mentioned that other women who had gone through labor and delivery were significant sources of information (for example, in terms of the characteristics of doctors or midwives), but they also factored in normative beliefs ("my sister said she'll never use a doctor again since she had a midwife deliver her baby").

Subjective Norms. Subjective norms are the degree to which the women felt it necessary to conform to the normative beliefs. In cases where the normative beliefs matched their own behavioral beliefs, conformity was a given. However, in situations in which normative beliefs were contradictory to behavioral beliefs, the pressure to conform seemed to be based on two main criteria. First was the importance of the significant other who held the contradictory belief. The most influential people in these situations were husbands, which supports the findings of Howell-White (1999) and Galotti et al. (2000) that women with supportive husbands were more likely to use midwives. Mothers also were particularly influential, though to a lesser extent than husbands. Second was the degree to which they felt confident about the experience of labor and delivery in that first-time mothers who encountered resistance in subjective norms were more likely to bow to that pressure than women in a subsequent pregnancy.

It is important to note that it seems that the attitude of the locality (town or city) can preclude choices to a large degree, often eliminating or limiting access to midwives in the first

place. The metropolitan area that was chosen for this study has a large number of midwives in practice on their own as well as in practice with doctors, and in fact the state has a midwife delivery rate that is higher than the national average. Women who had given birth in other places, both within the same state and in other states in various parts of the country, often mentioned how there were prevailing attitudes elsewhere that discouraged the use of midwives. An example is the belief that midwifery practices only serve the indigent, and as such, they are assumed to be second-rate or substandard to physician services. The belief that midwifery services are substandard is significant since studies have shown that quality considerations are often the most important factor when consumers are making decisions about credence goods (Ostrom & Iacobucci, 1995).

Control Beliefs. Control beliefs are factors that the women believed would either promote or detract from their ability to achieve their desired goal or behavior. Factors that the women believed could help or hinder the pursuit and achievement of their goals included type of birth attendant (midwife vs. obstetrician), hospital environment (including hospital regulations, nursing staff, and available equipment), and presence or absence of support in labor and delivery (midwife, coach, and others such as doulas, friends, sisters, or parents who would participate in the labor process). Information sources influenced these beliefs as did, to a large extent, the beliefs of others around them. For example, confidence in their ability to have an unmedicated birth was undermined by being continually told by other women (or seeing painful labors in media representations of labor and delivery) that even if they thought they wanted a natural labor, they would be screaming for pain medication. Belief in the strength and ability of women to deal successfully with labor also affected control beliefs. These beliefs included thinking that because birth is a natural process, women are equipped naturally with the ability to deal with the

associated pain, that women had been scared into believing they couldn't handle the pain of labor by media representations of birth (such as scenes of birth in television shows and movies), and, for a few women (4), Christian religious beliefs that the pain of labor was nothing in comparison to what their savior had been through for them.

Perceived Behavioral Control. Perceived behavioral control is a belief in one's own ability to achieve the desired behavior. This was very much affected by the degree of security of one's own knowledge, as evidenced by the women who had not used a midwife for their first birth experience. All of the women who had more than one child spoke of being much more confident for subsequent labors and deliveries and first-time mothers speculated that they would be more confident for future labors and deliveries. Women were also more confident in their abilities if those around them were confident and supportive too. Preparations that were made to facilitate their ability to achieve their desired outcome prior to going into labor also increased their confidence. These preparations included creating a written birth plan, putting in place a support system (such as having a labor coach or a doula), taking classes, reading, visiting the hospital, and physical preparation such as stretching exercises, yoga, chiropractic care, and general health and nutritional well-being preparation. For five of the women interviewed, these preparations also included planning to have a homebirth, where non-emergency medical interventions were unlikely to be an issue.

Given the information collected to date, there seems to be two different scenarios emerging regarding normative beliefs, subjective norms, and control beliefs and their effects on both perceived behavioral control and intentions. For some women (20), normative beliefs, subjective norms, and control beliefs all were supportive of their intended behavior. However, the remaining women were consciously choosing to place behavioral beliefs and attitudes toward

the behavior ahead of these other three concepts. The previously discussed example of intention to avoid the use of an epidural is a situation in which a woman is choosing an intention contrary to her normative beliefs, subjective norms, and control beliefs. This would seem to indicate that the intensity of the behavioral beliefs, and the perceived consequences of the behavior, can at times negate other issues.

Intention. This is the stated expression of one's desired behavior, outcome, or goal. As mentioned earlier, the women in this study had one or both of the following intentions.

1. Labor and delivery with the fewest medical interventions as would be safe and practical.
2. More personalized attention from their caregiver/birth attendant.

It seemed for many women the choice of a midwife was not the intended behavior (as in "a midwife will deliver my baby") but rather a mechanism to increase the likelihood of an intended behavior (such as having a "natural" birth or avoiding an episiotomy). It is important to note that not all women expressed such specific intentions when describing their choice of birth attendant, but rather expressed a general desire to have a positive, fulfilling birth experience and believed that a midwife would contribute significantly to the likelihood of achieving that desire.

Actual Behavioral Control. Actual behavioral control is how well perceived behavioral control works in reality. Here is where we see if the perceived helps/hindrances were predicted accurately. About half of the women (6) who had created written birth plans said the plans had little or no effect on what actually happened. These women believed that while the exercise of writing a birth plan may be useful in solidifying one's intentions, their actual benefits in the labor and delivery environment were negligible. However, the other half of the women interviewed did think that creating a birth plan had been useful in helping them to achieve their goals. These

mixed results may indicate that a written birth plan can be useful as part of a larger plan of action, rather than as a sole source of empowerment. Actual behavioral control also was impacted by supporters' willingness and ability to intervene when other factors arose that could lead the laboring woman away from desired goals. This was where midwives tended to be very important, especially if those contrary factors were part of the hospital environment (such as hospital policies and regulations or a non-supportive nursing staff). Midwives generally were seen as being more willing than obstetricians to make challenges in a hospital environment. These challenges included confronting nursing staff or doctors directly to challenge rules or policies or circumventing rules by doing things out of view of the hospital staff or creating subterfuge. Advocates were often (9) a major determinant of whether an intention was translated successfully into behavior.

It is at this point that the unpredictable aspects of labor and delivery can be factored into the process. All of the women acknowledged that the most important goal they had was delivering a safe and healthy baby. They were aware that there are circumstances that may require medical intervention, regardless of whether or not it was part of the plan. Indeed, several women (3) had epidurals to rest from an arduous labor so they would have the strength to continue with a vaginal delivery. Two women had cesarean-sections because it appeared that they would not be dilated sufficiently to deliver, or because the baby was not in a proper position for a successful vaginal delivery.

In many of the situations described in the interviews, the ability to translate intentions into behavior was affected by several things. First, it seems that women whose perceived behavioral control closely matched the actual behavioral control in the situation they faced were better prepared to deal successfully with obstacles that may have surfaced. Many of the women

(10) expressed sentiments along the lines of "no one tells you what it's really like!" which would indicate a lack of information or understanding about the actual behavioral control environment. This would seem to be a significant issue because everyone expressed a high level of information-seeking behavior (part of the behavioral belief process) in the process of making pregnancy, labor, and delivery decisions.

A specific example of an unknown factor for some women in the labor and delivery environment was hospital policies regarding specific issues (such as the intention to wear their own clothes during labor or the amount of time spent connected to an electronic fetal monitor during labor). For women unaware that hospital policies could interfere with their intentions, many (4) felt compelled to follow hospital policy once they arrived at the hospital in labor because they felt they were not able physically or emotionally to challenge the policy. Other women (3), however, were aware of hospital policies that could interfere with their intention to perform a certain behavior and took pre-emptive steps either to acquire the necessary permission to do what they wanted or to formulate a plan to circumvent the policy.

The women interviewed said that many pregnancy and childbirth guides suggested formulating a birth plan to increase the likelihood that labor and birth intentions would be realized in actual behavior. Birth plans are essentially written expressions of a woman's labor and delivery intentions, such as the preference for various interventions. Birth plans definitely seemed to influence perceived behavioral control (at least for the first birth for which one was written), as women are encouraged by many pregnancy guides to develop them in conjunction with their birth attendant. Women believed that their written plan would serve as a quasi-contract that would be recognized by attendants in the labor and delivery environment. However, six women who had written birth plans said that they were virtually worthless after

entering the hospital, due to either medical issues or resistance issues among hospital staff. Thus birth plans were perceived as giving women control over behavior, while in reality most women (10) felt that they were only marginally useful in helping women translate their intentions into behavior.

Therefore, in the case of labor and delivery, women consistently mentioned ways in which they attempted to increase the likelihood of being able to translate their intentions into behavior. One way was to have other significant players in the labor and delivery process commit to the same intentions. For all women, this involved having their husbands commit to the same intentions, and many women (13) involved their birth attendant (doctor or midwife), and to a certain degree, hospital nurses. The more people involved in the process who were committed to the intention, the stronger the "united front" that could be presented in situations in which following through with the intention was not a serious impediment to a safe and reasonable delivery.

Another way that women worked to increase the likelihood that they could turn their intentions into actual behavior was to alter in some way the environment in which actual behavioral control issues took place. For example, the five women who had homebirths took the significant step of having their labor and delivery at home where they were most likely to be able to exercise volitional control. Other women (12) took steps such as comparing hospital policies (when there was an option between two or more hospitals for the labor and delivery), laboring at home for as long as possible, or coming up with plans to circumvent potential obstacles (such as asking nursing staff to find Doppler monitoring devices to use in place of electronic fetal monitors).

Summary

Generally speaking, the women who participated in this study desired one or both of the following regarding the care they received during their pregnancy, labor, and delivery. Three-quarters of the women (23) specifically said they chose a midwife as their birth attendant because they wanted more sensitive care from their practitioner, which involved being concerned about mental and emotional well-being, spending more time with the women during their office visits and labor, and being willing to spend more time answering questions and discussing options. About half of the women specifically said they wanted to minimize the number of medical interventions used during labor and delivery, though the specific interventions varied from individual to individual. For some (8), this desire took the form of not wanting any intervention (drugs, episiotomies, electronic monitors, heparin locks) at all (expressed by all of the homebirth mothers and several (4) of the women who gave birth in hospital settings). Other women (9) were open to certain interventions (epidural anesthesia, for example), but wanted to avoid others (such as episiotomies).

What Helped/What Hindered

The main method the women chose to help them meet their desires and goals was by choosing a midwife as their birth attendant. All but one of the women believed that having a midwife did help them have the birth they wanted, or at least something close. Sometimes the reason they did not have exactly the birth they wanted was due to physiological issues beyond their or the midwives' control. These issues included not being sufficiently dilated for a vaginal delivery, babies in the wrong position for birth, stalled labor, or the health of the mother (such as high blood pressure or extreme fatigue). Other factors that prevented them from having exactly the labor and delivery experience they wanted included hospital policies that either prevented

them from doing something they wanted to do or made them do something they did not want. Occasionally the nursing staff at the hospital presented a barrier to meeting goals.

In addition to using a midwife, the women also found that having a well-prepared support system (labor coaches, doulas, other non-medical supporters) helped them to stick to their original plan for labor and delivery. Having everyone in agreement meant that time was not lost arguing about the pros and cons of various options. Also, having a midwife in the room for significant periods of time during labor meant that the labor coach could take breaks, which was important, especially for first labors that often could be quite long. The women who had used doulas also mentioned their importance as a source of relief for labor coaches. The additional supporters also could take over in the event that a labor coach was uncomfortable dealing with intense or graphic medical issues. All but one of the women who had a cesarean-section said that their midwife came into the operating room with them, which at that point was often purely for support to the birthing mother, offering comforting words or explaining what was taking place on the other side of the surgical drape.

Implications

Planning for childbirth involves economic, social, and medical issues. While there was a point in time when women automatically knew when they became pregnant that their family doctor would take care of their needs or send them to a specific obstetrician, the healthcare market in general, and the obstetrical market in particular, have taken on more and more characteristics of other consumer service markets. Women have a variety of choices (though these choices may be somewhat limited by insurance companies) for the type of healthcare provider they use (obstetrician or midwife), the type of environment in which they give birth (local hospitals, birthing centers, or homebirths), the way in which they deal with the pain of

labor (medical intervention, Lamaze method, Bradley method, Hypno-birthing, etc.), and what additional supportive persons they would like to have with them during labor and/or delivery. While making these decisions, women are subject to supportive or non-supportive opinions in their social environments and the options available to them in the city or town in which they reside. Last, but certainly not least, women are subject to natural forces outside their realm of control that often end up dictating what personnel will need to attend a birth and what medical interventions will be required.

Healthcare markets are becoming more and more consumer-oriented as evidenced by the increasing use of advertising by service providers and drug companies, the presence of consumer guidebooks to make healthcare-related decisions, and a healthcare industry focus on providing consumer-directed healthcare options. These aspects certainly are apparent in obstetrical markets, where there is great potential for repeat customers. The impending birth of a child presents a somewhat unique healthcare situation in which consumers (i.e., expectant women) have the time to investigate their options and educate themselves through a wide variety of resources. They also have relatively easy access to other consumers who have been in the same situation. For example, if one is in need of a gastroenterologist one might have to put in a bit of effort to find others who have used the services of such a specialist, while one usually can find women who have used obstetrical services quite easily among friends, family, co-workers—even the other women in line at the grocery store or working out at the gym.

The Theory of Planned Behavior presents a way to acknowledge and model the multifaceted nature of consumer decision-making in healthcare environments, incorporating consumer, psychological, and social factors, as well as the uncertainty factor, which can be a significant factor in childbirth. It also allows for incorporation of traditional consumer theories,

such as consumer information search theory, services, and consumer satisfaction theories. The Theory of Planned Behavior essentially allows for the many "what-ifs" that arise when making decisions about what a woman wants for her pregnancy and childbirth experiences.

There are several important reasons for studying what women want for their pregnancy and childbirth experiences. First, for women to get what they want from service providers, their thoughts and opinions must be heard. Qualitative studies such as this one can create a foundation of information that can be used for larger, more generalizable studies. Qualitative and quantitative studies together then would paint a more vivid and detailed picture of what women want from their birth attendants and birthing environments.

Secondly, understanding what women want can help to guide policy formation. For example, insurance companies in some states are required to cover midwifery services for homebirths while other states have no such mandates for insurance coverage. If it is determined that a significant number of women would like the option of having a homebirth, especially given the lower price of a homebirth (since there are no hospital fees), this could be a way to facilitate the creation of an environment where women have more options, without increasing healthcare costs. Thirdly, the American College of Obstetricians and Gynecologists has noted an obstetrician shortage in 23 states (including the state in which this study was conducted), with an additional three states being monitored for crisis situations. Midwifery services could be used to fill the gap created by the shortage of doctors in this field. By understanding what consumers want, policy and professional efforts can be aimed at the areas that women deem the most important.

Lastly, midwives and doctors alike can benefit from hearing what women have to say. In instances in which women express dissatisfaction with the nature of current obstetrical services,

service providers may be unaware of the dissatisfaction or the impact these unsatisfying and/or negative experiences can have on women. By opening a dialogue between women, midwives, and doctors, all of the parties can come together to develop practices and policies that create mutually beneficial situations for everyone involved.

Issues for Future Research

The following issues were not addressed in this research, but may be potentially interesting and important avenues for future investigation of consumer behavior in the maternal healthcare market. These topics cover both methodological and policy issues. Additionally, these are issues that potentially would be of interest to researchers from a variety of disciplines.

Survey research and quantitative analysis

A major limitation of this research project was the use of convenience and snowball sampling to produce data that should not be generalized to the larger population. The information generated by these interviews, however, can inform future research using both qualitative and quantitative methodologies. Additional qualitative interviews in different parts of the country, with more diverse populations, could confirm and/or add to the issues identified here as important to women who go through labor and delivery. Subsequent research then could use the information amassed in the qualitative interviews to create a set of questions answered by a larger sample selected more systematically to produce results that would be more generalizable to larger populations.

In terms of content, future research efforts (both qualitative and quantitative) should probe which of the characteristics of maternal health services are most associated with patient-driven healthcare. Additional research is needed on what leads to satisfaction as well as dissatisfaction with maternal health services. In addition, as the interviews suggested that

control was important to women in labor and delivery, a subset of the efforts should focus on the characteristics of maternal health services that women consider "non-negotiable," if any. By more specifically isolating the issues that are most important to women, service providers will have guidance about how to alter the healthcare environment and interpersonal interactions to provide women with the care they desire. These issues also should be analyzed with regard to cultural differences between groups of women in the United States. For example, are the issues that are important to white, middle- and upper-middle class women the same issues important to Latino or African American women? Do low-income consumers differ in their expectations of their healthcare providers and the environment in which they receive that care from more affluent consumers? Issues such as race, social class, and educational background could possibly influence the degree to which women are comfortable asserting their own authority in healthcare environments.

From a consumer perspective, future research could try to isolate the specific characteristics of maternal health services and then use that information with Lancaster's attribute theory (1966) to create hedonic price models. Lancaster postulated that goods and services should not be regarded as single entities, but rather as bundles of characteristics. Consumers value the individual characteristics differently, indicating which characteristics are the most important to them. This type of analysis could be used to identify those things that service providers in maternal healthcare markets should focus on for greater consumer/patient satisfaction. Healthcare providers could put more of their resources into these specific areas and/or charge premiums for certain additional services (for example, massage therapy during labor) that may appeal to certain segments of the consumer population. Additionally, it may be useful in future research to distinguish specific differences between those options that create

satisfaction and those that create dissatisfaction. There may be behaviors that service providers can *stop* doing to provide consumers with the experience they desire.

It may be useful to determine what prevents women who would have liked to use a midwife for their pregnancy, labor, and birth experiences from doing so. What is preventing them from putting their desires into action? How are they different from the women in this study who were able to implement a choice that the vast majority of women (90%) in the United States do not make? Potential barriers can include a variety of issues, including access to midwives, insurance requirements, perceptions of midwives, and overcoming social norms. Identifying the most common barriers will help determine what actions should be taken to make midwifery care a realistic and accessible option for all childbearing women.

Future research also should include a study of healthcare service providers and insurance practices. There may be reasons that healthcare consumers are not receiving what they want due to providers' inability or unwillingness to provide that type of service. For example, fear of lawsuits, malpractice insurance requirements, or understaffing may prevent many providers from doing certain things that consumers would prefer. Both sides of the market must be investigated to yield policy recommendations that are realistic and achievable. Additionally, the role that insurance companies play in this scenario also should be included in future research. Insurance companies play a somewhat unusual part in healthcare markets by acting as consumers when dealing with doctors, hospitals, and other service providers, but as service providers to healthcare consumers. The degree to which both healthcare consumers and providers feel constrained by insurance requirements may have a significant impact on the degree to which they feel they can demand and institute change.

Demographic Characteristics of Interviewers

The interviewer who conducted this research was a white, middle- to upper-middle class female who had never had a child and was not a parent. These characteristics seemed to facilitate the interviewing process in part because the women were careful to explain things that might be foreign to someone who had not been through childbirth. One-half of the women indicated that they preferred a female service provider for gynecological/obstetrical care, which could potentially indicate that they would be more comfortable with a female, rather than male, interviewer. If a qualitative study were to be undertaken in the future that involved a male interviewer, it would interesting to see if the women in that study were as forthcoming with their experiences and the sometimes personal nature of the details. Male interviewers who attended their own children's births might share their experiences as a way of creating a connection with the women they interview. Male interviewers who had not attended a birth might try to find an opportunity to do so (by, for example, making contacts with midwives who might know women who would be receptive to the idea of a researcher in the room during birth), to have a shared experience of sorts with the women they interview. If a larger qualitative study that involved multiple interviewers were undertaken, it might be helpful to ask prospective interviewees if they had a preference for the gender of the interviewer, so that they are interviewed in an environment in which they feel most comfortable. A self-administrated questionnaire would, of course, avoid the issue of gender altogether.

Pricing issues

Despite the fact that all but one of the women expressed satisfaction with their midwife and indicated that they would use a midwife in the future if one were available, the women were split as to whether they would be willing to pay out-of-pocket for midwifery services if that were

the only way they could use a midwife. Thirteen women said they would definitely pay for midwifery services if they were no longer covered by insurance, another six women said it would depend upon their financial circumstances at the time, and the remaining 11 would use an insurance-covered obstetrician. Future research could explore whether the strength of their satisfaction with a midwife was associated with their willingness to pay with their own resources. It may well be that the women who said the decision would depend on their financial resources at the time were putting the needs of others in the family ahead of their own preferences for midwifery services. If that is the case, the argument that women should not be forced to choose between their own needs and the financial priorities of their households potentially could justify passage of legislation requiring insurance companies to reimburse for licensed midwifery care. However, this change could run counter to the current trend to expect patients to take greater financial responsibility for their healthcare decisions.

Educating the general population about midwifery

Over one-third of the women indicated that they first learned about midwives after they became pregnant and were presented with the option to choose between a midwife and an obstetrician at their OB/GYN practice. Additionally, approximately one-quarter of the women indicated that they encountered some resistance to the use of a midwife from their husband, family members, or friends. This resistance was usually based upon a lack of information about modern midwifery care or in a belief that only the "very best" (i.e., a medical doctor trained in all aspects of gynecological and obstetrical care) should be used for something as precious as a child. These two observations together indicate that the general population may not be very well-informed about options currently available to pregnant women in the United States. Three-quarters of the women indicated that they conducted additional information search about

midwifery after choosing a midwife for their care. Among the women who faced resistance on the part of significant others, many (6) reacted by attempting to educate them using books and other information about midwives or by taking them to meet their midwife at an office appointment. Other women (4) just avoided the subject with people who believed that only obstetricians should attend deliveries. This overall lack of information indicates that organizations that support and promote midwifery need to expand their efforts to educate the general population. These efforts could include advertisements and articles in popular women's magazines (aimed at both women in general and pregnant women specifically), greater inclusion in popular books about pregnancy, and a higher profile on television shows that focus on pregnancy and childbirth. By creating a better informed public, women will be less likely to feel they are going against the norm by using a midwife. Additionally, the issue of always using the "very best" might be important to address in terms of educating the general population about cost-control measures in healthcare. As most "normal" pregnancies qualify for midwifery care, it could be a useful cost containment measure for consumers and insurance companies. Midwifery organizations, healthcare organizations, and insurance companies could coordinate their efforts in educating the public about the service and cost containment benefits of midwifery.

Application to other consumer healthcare markets

Some issues the women encountered in the maternal healthcare market can be found in other healthcare markets as well. For example, other patients desire approval of healthcare choices from significant others and may be less likely to get that approval if they make a nontraditional choice, such as might be experienced by a cancer patient who seeks to use an experimental therapy or someone who chooses to see a chiropractor or acupuncturist for pain

management. Several women brought up issues they had with hospital policies—do other hospital consumers/patients have similar complaints or lack of knowledge about hospital policies in general? Identifying these issues in other healthcare markets can help guide service providers and policymakers in creating environments in which consumers/patients feel most comfortable.

Conclusion

There are a myriad of issues that come into play when a woman is choosing who will attend the birth of her children. These issues are financial, social, psychological, and legal in nature. The choice of birth attendant is both personal and public at the same time, in that women are making a decision of a very personal and intimate nature when they choose the person who will share some of the most important moments of their lives with them. However, in the aggregate these decisions form patterns in society that have implications for the future of healthcare delivery in the United States. Women have the potential to influence and direct the industries that are involved in childbirth decisions (the medical profession, hospitals, and insurance companies) and government legislation that organizes and directs some of the activity in this healthcare environment. Hopefully, this research will add to existing and future research to help women to be more active participants in shaping maternal healthcare delivery.

References

Abraham, C., & Sheeran, P. (2003). Acting on intentions: The role of anticipated regret. *British Journal of Social Psychology, 42,* 495-511.

Adams III, A.F., Ekelund Jr., R.B., & Jackson, J.D. (2003, January). Occupational licensing of a credence good: The regulation of midwifery. *Southern Economic Journal, 69*, 659-675.

Aizen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhi & J. Beckmann (Eds.), *Action-control: From cognition to behavior* (pp.11-39). Heidelberg: Springer.

Aizen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs, NJ: Prentice Hall.

Alba, J.W., & Hutchinson, J.W. (2000). Knowledge calibration: What consumers know and what they think they know. *Journal of Consumer Research, 27*, 123-156.

American College of Nurse-Midwives. (2002a). Births attended by certified nurse-midwives are on the rise! Retrieved November 12, 2002, from http://www.midwife.org/prof/display.cfm?id=79

American College of Nurse-Midwives. (2002b). *Certified nurse-midwives in Georgia*. Retrieved February 17, 2005, from http://www.midwife.org/prof/display.cfm?id=17

Andrews, R.L. (1992). Economics of information and heterogeneous products. *Journal of Economic Psychology, 13*, 399-420.

Armitage, C.J. (2003). Beyond attitudinal ambivalence: Effects of belief homogeneity on attitude-intention-behavior relations. *European Journal of Social Psychology, 33*, 551-563.

Armitage, C. J., Norman, P., & Conner, M. (2002). Can the theory of planned behaviour mediate the effects of age, gender and multidimensional health locus of control? *British Journal of Health Psychology, 7,* 299-316.

Avery, R.J. (1992, August). Determinants of search for non-durable goods: An empirical assessment of the economics of information theory. *Journal of Consumer Affairs, 30*, 390-419.

Babin, B.J., Darden, W.R., & Griffin, M. (1994). Work and/or fun: Measuring hedonic and utilitarian shopping value. *Journal of Consumer Research, 20*, 644-656.

Barnes, N.G. (1985). What Dewey didn't tell us: A closer look at our basic assumptions in marketing health services. *Journal of Health Care Marketing, 5*, 59-61.

Barry, C.A. (1998). Choosing qualitative data analysis software: Atlas/ti and NUD*IST compared. *Sociological Research Online*. Retrieved December 2, 1999, from http://www.socresonline.org.uk/socresonline/3/3/4.html

Beatty, S.E., & Smith, S.M. (1987, June). External search effort: An investigation across several product categories. *Journal of Consumer Research, 14*, 83-95.

Blevins, S.A. (1995). The medical monopoly: Protecting consumers or limiting competition? *Policy Analysis, 246*, 1-34. Retrieved from http://www.cato.org/pubs/pas/pa-246.html

Bloch, P.H., Sherrell, D.L., & Ridgway, N.M. (1986, June). Consumer search: An extended framework. *Journal of Consumer Research, 13*, 119-126.

Bradley, R.A., & Montagu, A. (1996). *Husband-coached childbirth: The Bradley method of natural childbirth*. New York: Bantam.

Brucks, M. (1985, June). The effects of product class knowledge on information search behavior. *Journal of Consumer Research, 12*, 1-16.

Brucks, M. (1988, June). Search monitor: An approach for computer-controlled experiments involving consumer information search. *Journal of Consumer Research, 15*, 117-121.

Caswell, J.A., & Mojduszka, E.M. (1996). Using informational labeling to influence the market for quality in food products. *American Journal of Agricultural Economics, 78*, 1248-1253.

Chang, Y.R., & Hanna, S. (1992). Consumer credit search behavior. *Journal of Consumer Studies and Home Economics, 16*, 207-227.

Childbirth tops reasons for hospital stays. (2003). *Marketing Healthcare Services, 23*, 6.

Citizens for Midwifery. (n.d.) *What is Citizens for Midwifery?* Retrieved March 23, 2004, from http://www.cfmidwifery.org/whatis/

Coleman, W., Warren, W.E., & Huston, R. (1995). Perceived risk and the information search process in the selection of a new dentist: An empirical investigation. *Health Marketing Quarterly, 13*, 27-41.

Cude, B.J. (1989). Consumer response to telecommunications deregulation: The equal access decision. *The Journal of Consumer Affairs, 23*, 285-300.

Cude, B.J. (1990). Telecommunications deregulation and rural consumers: The impact on decision-making. *Journal of Consumer Studies and Home Economics, 14*, 205-214.

Cutlip, K. (1997, Summer). Midwifery goes mainstream as hospitals expand options and cut costs. *Hospital Topics, 75*, 17-22.

Darby, M.R., & Karni, E. (1973). Free competition and the optimal amount of fraud. *Journal of Law and Economics, 16*, 67-88.

Davies, R. (2000, October). Qualitative and quantitative market research. *Orient Pacific Century Market Research*. Retrieved January 10, 2004 from http://www.asianmarketresearch.com/columns/market5.htm

DeBono, K.G., & Omoto, A.M. (2001). Individual differences in predicting behavioral intentions from attitude and subjective norm. *Journal of Social Psychology, 133,* 825-831.

Declercq, E. (1992, May). The transformation of American midwifery: 1975-1988. *American Journal of Public Health, 82*, 680-684.

Declercq, E. (1998, October). Changing childbirth in the United Kingdom: Lessons for U.S. health policy. *Journal of Health Politics, Policy, and Law, 23*, 833-859.

Declercq, E.R., Sakala, C., Corry, M.P., Applebaum, S., & Risher, P. (2002). *Listening to mothers: Report of the first national U.S. survey of women's childbearing experiences*. New York: Maternity Center Association.

DeVries, R.G. (1996). *Making midwives legal: Childbirth, medicine, and the law*. Columbus: Ohio State University Press.

Dewitte, S., Verguts, T., & Lens, W. (2003). Implementation intentions do not enhance all types of goals: The moderating role of goal difficulty. *Current Psychology: Developmental, Learning, Personality, Social, 22,* 73-89.

Duncan, C.P., & Olshavsky, R.W. (1982, February). External search: The role of consumer beliefs. *Journal of Marketing Research, 19*, 32-43.

Eakins, P.S. (1986). *The American way of birth*. Philadelphia: Temple University Press.

Eichner, M.J. (1998, May). The demand for medical care: What people pay does matter. *American Economics Association Papers and Proceedings, 88*, 117-121.

Eisenberg, A., Murkoff, H.E., & Hathaway, S.E. (1996). *What to expect when you're expecting*. New York: Workman Publishing Company, Inc.

Emons, W. (1997, Spring). Credence goods and fraudulent experts. *The Rand Journal of Economics, 28*, 107-119.

England, P. (1993). *Theory on gender, feminism on theory*. Hawthorne (NY): Aldine de Gruyter.

Farley, S. (2004). Women want their midwives! *American College of Nurse-Midwives Press Release*. Washington, D.C.: American College of Nurse-Midwives.

Fekadu, Z., & Kraft, P. (2001). Self-identity in planned behavior perspective: Past behavior and its moderating effects on self-identity-intention relations. *Social Behavior & Personality, 29*, 671-685.

Fiesta, J. (1995). Obstetrical liability, Part III: Nurse-midwives. *Nursing Management, 26*, 31-34.

Francese, P., & Edmondson, B. (1986). *Health care consumers: A handbook of trends, techniques, and information sources for healthcare executives*. Ithaca: American Demographics Institute.

Galotti, K.M., Pierce, B., Reimer, R.L., & Luckner, A.E. (2000, July/August). Midwife or doctor: A study of pregnant women making delivery decisions. *Journal of Midwifery and Women's Health, 45*, 320-329.

Ganzach, Y., & Mazursky, D. (1995). Time dependent biases in consumer multi- attribute judgment. *Journal of Economic Psychology, 16*, 331-349.

Geron, S.M. (2000, Fall). The quality of consumer-directed long-term care. *Generations*, 66-73.

Glaser, B.G., & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publishing Company.

Goldman, F., & Grossman, M. (1976). The demand for pediatric care: A hedonic approach. *National Bureau of Economic Research, Working Paper #134*.

Goldman, A., & Johansson, J.K. (1978, December). Determinants of search for lower prices: An empirical assessment of the economics of information theory. *Journal of Consumer Research, 5*, 176-186.

Graham, R.J. (1981, March). The role of perception of time in consumer research. *Journal of Consumer Research, 7*, 335-342.

Gupta, P., & Ratchford, B.T. (1992). Estimating the efficiency of consumer choices of new automobiles. *Journal of Economic Psychology, 13*, 375-397.

Halliday, S.V. (2000). Maternity care: Ways to add value. *The Services Industry Journal, 20*, 131-146.

Halliday, S.V., & Hogarth-Scott, S. (2000). New customers to be managed: Pregnant women's views as consumers of healthcare. *Journal of Applied Management Studies, 9*, 55-69.

Harris Interactive. (2001). Health Care News. Retrieved February 17, 2004, from http:// www.harrisinteractive.com/news

Hay, J.W., & Olsen, R.J. (1984, July). Let them eat cake: A note on comparing alternative models of the demand for medical care. *Journal of Business and Economic Statistics, 2*, 279-282.

Heath, H., & Cowley, S. (2003, September). Developing a grounded theory approach: A comparison of Glaser and Strauss. *International Journal of Nursing Studies. 41*, 141-150.

Howell-White, S. (1997). Choosing a birth attendant: The influence of a woman's childbirth definition. *Social Science and Medicine, 45*, 925-936.

Howell-White, S. (1999). *Birth alternatives: How women select childbirth care*. Westport: Greenwood Press.

Hunt-McCool, J., Kiker, B.F., & Ng, Y.C. (1994). Estimates of the demand for medical care under different functional forms. *Journal of Applied Econometrics, 9*, 201-218.

Issanchou, S. (1996). Consumer expectations and perceptions of meat and meat product quality. *Meat Science, 43*, S5-S19.

Jacobson, R., & Obermiller, C. (1989). The formation of reference price. *Advances in Consumer Research, 16*, 234-240.

Jacoby, J., Speller, D.E., & Berning, C.K. (1974, June). Brand choice behavior as a function of information load: Replication and extension. *Journal of Consumer Research, 1*, 33-42.

Johnson, B., & Fansler, D. (2002, February). How consumerism will drive healthcare purchasing decisions in 2002 and beyond. *Partners' Perspective, 3*, 1-5.

Jun, M., Peterson, R.T., & Zsidisin, G.A. (1998). The identification and measurement of quality dimensions in healthcare: Focus group interview results. *Health Care Management Review, 23*, 81-96.

Keaveney, S.M. (1995, April). Customer switching behavior in service industries: An exploratory study. *Journal of Marketing, 59*, 71-82.

Kelly, K. (2002, September). The midwife option. *American Baby Magazine, 64*, 37-38.

Kenkel, D. (1990). Consumer health information and the demand for medical care. *The Review of Economics and Statistics*, 587-595.

Kennedy, H.P. (2002). The midwife as an instrument of care. *American Journal of Public Health, 92*, 1759-1760.

Kiel, G.C., & Layton, R.A. (1981, May). Dimensions of consumer information seeking behavior. *Journal of Marketing Research, 18*, 233-239.

Kim, J.C. (1992, March). Experience goods, expectations, and pricing. *Economic Record, 68*, 7-15.

King, K.W., & Haefner, J.E. (1988, June). An investigation of the external physician search process. *Journal of Health Care Marketing, 8*, 4-13.

Kurland, N.B. (1995). Ethical intentions and the theories of reasoned action and planned behavior. *Journal of Applied Psychology, 25*, 297-313.

Laband, D.N. (1991). An objective measure of search versus experience goods. *Economic Inquiry, 29*, 497-509.

Lancaster, K.J. (1966). A new approach to consumer theory. *Journal of Political Economy, 84*, 132-156.

Lay, M.M. (2000). *The rhetoric of midwifery: Gender, knowledge, and power*. New Brunswick: Rutgers University Press.

Lee, J., & Hogarth, J.M. (2000a). The relationship among information search activities when shopping for a credit card. *Journal of Consumer Affairs, 34*, 330-360.

Lee, J., & Hogarth, J.M. (2000b). Shopping for a credit card: The search for information. *Consumer Interests Annual, 46*, 115-120.

Lee, J., & Hogarth, J.M. (2000c). Consumer information search for home mortgages: Who, what, how much, and what else? *Financial Services Review, 9*, 277-293.

Liebeskind, J., & Rumelt, R.P. (1989). Markets for experience goods with performance uncertainty. *The Rand Journal of Economics, 20*, 601-621.

Lin, Q. (2002). *Consumers' information search when making investment decisions*. Unpublished thesis, University of Georgia.

Lynch, J.G., & Srull, T.K. (1982). Memory and attentional factors in consumer choice: Concepts and research methods. *Journal of Consumer Research, 9*, 18-37.

Marmorstein, H., Grewal, D., & Fishe, R.P.H. (1992, June). The value of time spent in price-comparison shopping: Survey and experimental evidence. *Journal of Consumer Research, 19,* 52-61.

Marshall, B.S., Javalgi, R.G., & Gombeski, W.R. (1995). Providing services to obstetrical patients: An overview and implications. *Health Marketing Quarterly, 13*, 63-78.

Marvel, H.P. (1976). The economics of information and retail gasoline price behavior: An empirical analysis. *Journal of Political Economy, 84*, 1033-1060.

Maute, M.F., & Forrester, W.R., Jr. (1991). The effect of attribute qualities on consumer decision making: A causal model of external information search. *Journal of Economic Psychology, 12*, 643-666.

Mayer, R.N. (1989). *The consumer movement: Guardians of the marketplace*. Boston: Twayne Publishers.

Mayer, R.N. (1998). Thoughts on women's contributions to the modern consumer movement. *Advancing the Consumer Interest, 10*, 5-13.

McCluskey, J.J. (2000). A game theoretic approach to organic foods: An analysis of asymmetric information and policy. *Agricultural and Resource Economics, 29*, 1-9.

Melton, M.R., & Trevino, L.J. (2001, December). Quality signals and experience goods: Higher education. *Atlantic Economic Journal, 29*, 474.

Midwives Alliance of North America. (2004). Definitions. Retrieved March 20, 2004 http://www.mana.org/definitions.html

Mitford, J. (1992). *The American way of birth*. New York: Dutton/Penguin Group.

Monroe, P.A. (1985). *Family health care decision making*. Unpublished dissertation, University of Georgia.

Moore, W.L., & Lehmann, D.R. (1980, December). Individual differences in search behavior for a nondurable. *Journal of Consumer Research, 7*, 296-307.

Murkoff, H., Eisenberg, A., & Hathaway, S. (2002). *What to expect when you're expecting*. New York: Workman Publishing.

Murphy, E., & Dingwall, R. (2003). *Qualitative methods and health policy research*. New York: Aldine de Gruyter.

Neelamegham, R., & Jain, D. (1999). Consumer choice process for experience goods: An econometric model and analysis. *Journal of Marketing Research, 36*, 373-386.

Nelson, P. (1970, March/April). Information and consumer behavior. *Journal of Political Economy, 78*, 311-329.

Newman, J.W., & Lockeman, B.D. (1975, December). Measuring prepurchase information seeking. *Journal of Consumer Research, 2,* 216-222.

Newman, J.W., & Staelin, R. (1972). Prepurchase information seeking for new cars and major household appliances. *Journal of Marketing Research, 9*, 249-257.

Number of women choosing nurse-midwives has doubled in last decade. (2004, January 28). *Biotech Week*, 22.

Oakley, A. (1981). Interviewing women: A contradiction in terms. In H. Roberts (Ed.), *Doing feminist research* (pp. 30-61). Boston: Routledge & Kegan Paul.

Office of Technology Assessment. (1986). Nurse practitioners, physician assistants, and certified nurse-midwives: A policy analysis. *Health Technology Case Study 37, OTA-HCS-37*. Washington, D.C.: U.S. Government Printing Office.

Olshavsky, R.W., & Kumar, A. (2001). Revealing the actual roles of expectations in consumer satisfaction with experience and credence goods. *Journal of Consumer Satisfaction, Dissatisfaction, and Complaining Behavior, 14*, 60-73.

Olshavsky, R.W., & Summers, J.O. (1974, June). A study of the role of beliefs and intentions in consistency restoration. *Journal of Consumer Research, 1*, 63-70.

Ophuis, P.A., & Vantrijp, H.C. (1995). Perceived quality: A market driven and consumer oriented approach. *Food Quality and Preference, 6*, 177-183.

Ostrom, A., & Iacobucci, D. (1995, January). Consumer trade-offs and the evaluation of services. *Journal of Marketing, 59*, 17-28.

Park, W.C., Mothersbaugh, D., & Feick, L. (1994). Consumer knowledge assessment. *Journal of Consumer Research, 21*, 71-83.

Pauly, M., & Satterhwaite, M. (1981). Pricing of primary care physicians' services: A test of the role of consumer information. *Bell Journal, 12*, 488-506.

Peltier, J.W., Boyt, T., & Schibrowsky, J.A. (1999, Fall). Obstetrical care and patient loyalty: Using satisfaction vs. quality to measure performance of a critical health service. *Marketing Health Services, 19*, 4-13.

Peltier, J.W., Boyt, T., & Schibrowsky, J.A. (2000, Spring). Obstetrical care and patient loyalty part two: Service performance can be linked to patient loyalty. *Marketing Health Services, 19*, 12-20.

Pierro, A., Mannetti, L., & Livi, S. (2003). Self-identity and the theory of planned behavior in the prediction of health behavior and leisure activity. *Self & Identity, 2,* 47-60.

Powers, T.L., & Bendall-Lyon, D. (2003, Fall). The satisfaction score. *Marketing Health Services, 23*, 28-33.

Puig-Junoy, J., Saez, M., & Martinez-Garcia, E. (1998, September). Why do patients prefer hospital emergency visits? A nested multinomial logit analysis for patient-initiated contacts. *Health Care Management Science, 1*, 39-52.

Punj, G.N., & Staelin, R. (1983, March). A model of consumer information search behavior for new automobiles. *Journal of Consumer Research, 9*, 366-380.

Ratchford, B.T. (1982). Cost-benefit models for explaining consumer choice and information seeking behavior. *Management Science, 28*, 197-212.

Ratcliff, D. (2002). *Qualitative research resources: Data analysis*. Retrieved November 2, 2003, http://don.ratcliff.net/qual/expq5.html

Rosen, D.L., & Olshavsky, R.W. (1987). The dual role of informational social influence: Implications for marketing management. *Journal of Business Research, 15*, 123-144.

Rothman, B.K. (1991*). In labor: Women and power in the birthplace*. New York: W.W. Norton and Company.

Rushing, B. (1993, February). Ideology in the reemergence of North American midwifery. *Work & Occupations, 20*, 46-68.

Saunders-Goldson, S., & Edwards, Q.T. (2004). Factors associated with breastfeeding intentions of African-American women at military health facilities. *Military Medicine, 169,* 111-116.

Sears, W., & Sears, M. (1994). *The birth book: Everything you need to know to have a safe and satisfying birth.* Boston: Little, Brown and Company.

Seltman, K. (2003, Winter). Iceberg ahead? *Marketing Healthcare Services, 23*, 3.

Sheeran, P., & Orbell, S. (1999). Augmenting the theory of planned behavior: Roles for anticipated regret and descriptive norms. *Journal of Applied Social Psychology, 29*, 2107-2142.

Sheeran, P., Trafimow, D., Krystina A., Finlay, K.A., & Norman, P. (2002). Evidence that the type of person affects the strength of the perceived behavioural control-intention relationship. *British Journal of Social Psychology, 41,* 253-270.

Shroff, F.M. (1997). *The new midwifery: Reflections on renaissance and regulation*. Toronto: Women's Press.

Simkins, G. (1998). Midwifery as a sustainable community model for providing women's health care. *Synapse, 44*, 1-6.

Slama, M.E., & Tashchian, A. (1985). Selected socioeconomic and demographic characteristics associated with purchasing involvement. *Journal of Marketing, 49*, 72-82.

Smith, J.M. (1992). *Women and doctors*. New York: The Atlantic Monthly Press.

Solovitch, S. (2001, September). The citizen scientists. *Wired*, 145-151.

Sparks, P., & Guthrie, C.A. (1998). Self-identity and the theory of planned behavior: A useful addition or an unhelpful artifice? *Journal of Applied Social Psychology, 28*, 1393-1410.

Sproles, G.B., Geistfeld, L.V., & Badenhop, S.B. (1978). Informational inputs as influences on efficient consumer decision-making. *The Journal of Consumer Affairs, 12*, 88-103.

Srinivasan, N. (1986). A path analytic model of external search for information for new automobiles. *Advances in Consumer Research, 14*, 319-322.

Srinivasan, N., & Ratchford, B.T. (1991). An empirical test of a model of external search for automobiles. *Journal of Consumer Research, 18*, 233-242.

Stichler, J.F., & Schumacher, L. (2003). The gift of customer complaints. *Marketing Healthcare Services, 23*, 14-15.

Stigler, G.J. (1961, June). The economics of information. *The Journal of Political Economy, 69*, 213-225.

Stoil, M.J. (2000, January/February). Consumerism comes to behavioral care. *Behavioral Health Management, 20*, 8-11.

Strauss, A.L. (1987). *Qualitative analysis for social scientists*. New York: Cambridge University Press.

Strauss, A.L. (1994). *Qualitative analysis for social scientists*. New York: Cambridge University Press.

Strauss, A.L., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park (CA): Sage Publications.

Swagler, R. (1994). Evolution and applications of the term consumerism: Theme and variation. *Journal of Consumer Affairs, 28*, 347-360.

Tong, R. (1989). *Feminist thought: A comprehensive introduction*. Boulder: Westview Press.

Trochim, W.M. (2000). *The research methods knowledge base, 2nd edition*. Retrieved January 19, 2001 from http://trochim.human.cornell.edu/kb/index.htm

Udell, J.G. (1966). Prepurchase behavior of buyers of small electrical appliances. *Journal of Marketing, 30*, 50-52.

Urbany, J.E. (1986). An experimental examination of the economics of information. *Journal of Consumer Research, 13*, 257-271.

U.S. Census Bureau. (2001). U.S. Census Bureau 2001 supplementary survey. Retrieved April 28, 2005 from http://www.census.gov/acs/www/Products/Profiles/Single/2001/SS01/ Narrative/ 380/NP38000US0520.htm

White-Means, S.I. (1989). Consumer information, insurance, and doctor shopping: The elderly consumer's perspective. *The Journal of Consumer Affairs, 23*, 45-64.

Zadoroznyj, M. (1999). Social class, social selves, and social control in childbirth. *Sociology of Health and Illness, 21*, 267-289.

Zeithaml, V.A., Parasuraman, A., & Berry, L.L. (1985, Summer). Problems and strategies in services marketing. *Journal of Marketing, 49*, 33-46.