

Commentary: What Is This Thing Called “Control”?

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For some years now “choice” and “control” have been buzzwords in discussions of women’s experiences of maternity care. The trouble with buzzwords is that they often mean very different things to different people, and can become effectively meaningless for that reason. Thus, research such as that reported by VandeVusse (1), which tries to elucidate the meaning of these key terms, is to be greatly welcomed.

Many studies have now told us that a sense of control is a major factor contributing to a woman’s assessment of her birth experience and her subsequent well-being. This study adds to the growing number (2–7) that are helping us to answer the next questions: “What is control?” and “How is it acquired or lost?”

Bramadat and Driedger (6) made the important observation that “satisfaction” is not just *having* a positive experience but is a positive evaluation of that experience, in other words that it has an affective component. That insight should focus us on the fact that the sense of “having” or “being in” control is similarly not an objective state; it is how the woman perceives the situation. But so, too, is a woman’s assessment of her input to decisions. As I read the examples given in this paper, I wondered how some of these vignettes might have been described differently seen through other eyes, for example that of the caregiver. In most cases the end result in terms of procedures carried out is the same. The difference lies in the woman’s perception, and the methodology of this study—using women’s detailed self-structured accounts—is thus highly appropriate.

It is a pity that VandeVusse weakens her paper in the discussion by equating three very different things “low intervention,” “evidence-based care,” and “respecting women’s choices.” What of the woman who wants interventions? The woman who wants something which is not supported by evidence? The woman

who wants something that her caregivers believe to be ineffective or even harmful? Caregivers may have to choose between giving a woman the care that they believe to be best and giving a woman what she wants. But that is another debate.

VandeVusse based her research on the birth stories of 15 women. It is therefore making no claims to be a representative survey. Rather, it has used recognized techniques of qualitative analysis to tease out the patterns in women’s accounts. From these, the author has devised a “model,” that is, a formal representation of the relationship between the parameters of interest. The parameters in this case are “control,” “decision making,” and “expressed emotions” (i.e., the words that women use when talking about these experiences). What is fascinating to me is that one word shines through the model without appearing in Figure 1 at all (1), and that is “respect.” The model is saying that when women feel respected they feel good, and when they don’t they feel bad. That is the take-home message for caregivers.

Each small qualitative study can add a new piece to the jigsaw. It is interesting to juxtapose this one with two recent British studies that were also based on women’s accounts of their births. Bluff and Holloway (8) interviewed 11 women in the maternity unit of a general hospital. They used the grounded theory method of qualitative analysis, which attempts to elicit from the data a “core construct” within which all other codings can be subsumed. The core construct that emerged from their analysis was “they know best”; that is, midwives are the experts and women therefore trust them. One particular quotation says a great deal (8, p 160):

I hadn’t really wanted an epidural, but they said “we feel it might be best,” but it was a case of “would you like it?” I did have choice, but I wouldn’t have had it [the epidural] if they hadn’t said it was best.

Although the idea that “they know best” seems at first to be at odds with the findings of VandeVusse’s study, in fact this quotation chimes exactly with her data in showing the way in which the presentation of

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an issue is critical to the woman's sense of control. Furthermore, it underlines the link apparent in VandeVusse's quotations between feeling respected/in control and trusting your caregiver. As I have argued elsewhere (3), for many women it is likely that the belief that "they know best"—that one is being cared for by experts—is essential to feeling in control. The alternative feeling—that one is being cared for by people who do not know what they are doing—would almost certainly lead to a feeling of panic and loss of control in all but the most confident woman. Given this need to believe in the staff's expertise, the woman will nearly always follow the staff's advice, but the belief that she *could* have made a different choice enhances her sense of control.

In the other study, by Walker et al (9), also using a grounded theory approach, the core construct was the balance between personal control and support. Control came from being able to have support (i.e., the midwife's presence) when it was wanted and not when it was not, and from being able to hand over control or let the midwife take control when appropriate. Thus, women were able to make comments such as, "it was great, she took control," because the midwife taking control at the appropriate moment was perceived as highly supportive. This would seem to take us even further from VandeVusse's analysis: the idea of women wishing to relinquish control does not appear in her model. Perhaps this is a function of her sample selection, but perhaps we are back to the question of just what is this thing called control? I would argue that the woman quoted by Walker et al *gained a sense of control by abdicating decision-making responsibility*. This is not allowed for in VandeVusse's model because control is defined in terms of decision making. But it need not be. Feeling in control could also mean, for

example, feeling confident and calm or an absence of feelings of panic (7). Decision making is just one of a number of components, and, as the Great Expectations study showed in 1988 (2,3,10), "making decisions" and "feeling in control of what doctors and midwives are doing" are not necessarily the same thing, and it is the latter that appears to be more important.

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