

CHAPTER 13

NATURALISTIC OBSERVATION: MIDWIVES' ETHNIC STEREOTYPING OF THEIR PATIENTS

EXEMPLAR Bowler, Isobel (1993) '“They're not the same as us”: midwives' stereotypes of South Asian descent maternity patients', *Sociology of Health and Illness*, 15 (2): 157–78

What you need to understand in order to understand the exemplar
What strengths a naturalistic observation study has over an interview study. <i>See Chapter 16, Section 3</i>
The importance for readers of knowing what role the observer played in the setting observed; how it would make some things visible and not others. <i>See Chapter 16, section 3</i>
The particular difficulty that observer researchers have in giving an account of their research to readers. <i>See Chapter 16, section 7</i>
What it means to analyse data thematically. <i>See Chapter 16, sections 2 and 6</i>
The issue of sympathetic bias in research. <i>See Chapter 16, section 7</i>
The ethical issues of informing those studied of the uses to which the data will be put. <i>See Chapter 16, section 3</i>
For any terms which are unfamiliar, try the index.

Introduction

The exemplar for this chapter is a report on a piece of non-participant observation research, though it included some pre-scheduled loosely structured interviews, and what Bowler calls 'natural interviews', by

which she means that she asked questions and gained responses as and when opportunities arose in the course of the routine activities of the maternity unit she was studying. The major claim of any piece of naturalistic research is to give an account of how things normally happen, and that includes giving some attention to how the presence of an observer might have altered what there was to observe. It is not clear from the study as to how the people Bowler observed understood her research interests, and hence it is not clear how the presence of an observer might have influenced what was said and done. However, given that the final write-up is very unflattering to them, it seems unlikely that the midwives were fully aware of the picture Bowler was developing of them. Bowler states that nearly all of the data came from the natural interviews and from things said in the course of ordinary activities. These are both circumstances which, by comparison with a more formal interview, would make it more difficult for respondents to manage the impression they were giving to the researcher.

‘THEY’RE NOT THE SAME AS US’: MIDWIVES’ STEREOTYPES OF SOUTH ASIAN DESCENT MATERNITY PATIENTS

Isobel Bowler

Abstract

The paper examines the stereotypes of South Asian descent women held by midwives in a British hospital. The data are drawn from a small-scale ethnographic study which investigated the women's maternity experiences. The midwives' stereotype contained four main themes: the difficulty of communicating with the women; the women's lack of compliance with care and abuse of the service; their tendency to 'make a fuss about nothing'; and their lack of 'normal maternal instinct'. The creation, perpetuation and effects of this negative stereotyping are examined in the light of the wider sociological research on patient typification. [. . .] Midwives used stereotypes to help them to make judgements about the kind of care different women want, need and deserve. It is therefore argued that stereotyping is a factor in the creation of the inequality in health experiences of black and minority ethnic patients.

Introduction

This paper presents findings from a small-scale ethnographic study of the delivery of maternity care to South Asian descent maternity patients. The stereotypes of these

women held by health service staff (in particular midwives) are examined and set in the context of observational data. The South Asian descent women were generally referred to and regarded as 'Asian' women by midwives and other personnel. This term is also common in the literature (e.g. Rathwell, 1984: 123), but it masks heterogeneity in national, religious, and cultural background. However, because of the lack of differentiation by the midwives, their category of 'Asian' will be used in this paper.

The research was carried out in the maternity department of a teaching hospital in Britain in 1988. All the women received shared consultant directed care.¹ The hospital serves a city in southern England which has a South Asian descent population estimated² around 8 per cent, or 8,000 people. The largest group, about half of the Asian population, is of Pakistani descent. This group has a younger age structure and higher fertility rate than the British population as a whole (Coleman and Salt, 1992; Diamond and Clarke, 1989; C. Shaw, 1988). This results in a greater consumption of maternity services than would be expected from a consideration of numbers alone.

During fieldwork it became apparent that patient typification and labelling were common. The categorisation of clients as 'good', or more usually 'bad', is a routine feature of bureaucracies (Protas, 1979) and medical settings are no exception (Kelly and May, 1982). In addition to individual patients being assigned a 'moral status', recognisable groups are likely to attract stereotypes. Midwives and other staff expressed stereotyped views of South Asian descent women which related to their customs and culture as well as their moral status as patients. The quotation in the title comes from an interview with a community midwife, and illustrates the common theme in the accounts: that 'they' are different from 'us'.

Midwives use stereotypes to help them pitch their interactions with women appropriately (Macintyre, 1978) and to make assumptions about the kind of care which different women want (Green et al., 1990). In the present study both of these observations held true. In addition, midwives used stereotypes to make assumptions about the kind of care different women deserve.

Midwives' views are contrasted with observational data which show that these were often contradicted by reality. However, midwives did not always recognise (or acknowledge) that individual women did not fit the stereotype. Even where midwives acknowledged a contradiction between experience and stereotype this did not necessarily cause them to question their view, but rather to treat the mismatch as the exception which proves the rule.

Green et al. (1990) and Macintyre (1978) report typifications of white women. Midwives in the present study also expressed stereotyped views of white mothers, although few data on this were collected. Examples given were of the 'thick' women from the large council estate and the educated NCT (National Childbirth Trust) middle class university women. Some of the aspects of the 'working class' stereotypes (e.g. low intelligence, lack of compliance) are present in the 'Asian' stereotypes. Indeed, the Asian women in the present study were all working class. However, this does not fully explain the extreme negative typification they suffered. The typifications go beyond class and echo the stereotypes of black and minority ethnic people common in wider society. The issue of racism (and anti-racism) is extremely complex (Gilroy, 1987) and beyond the scope of the present paper. Implicit throughout, however, is a recognition of the power relations between black women and white staff (Pearson, 1986).

Methods

The fieldwork with midwives³ was carried out by the author alone over a three month period in the Summer of 1988. Access to the midwives and the maternity hospital was negotiated with the Director of Midwifery Services for the District Health Authority. The main method of data collection was observation, which was supported by data from interviews with twenty-five midwives.

The majority of the women observed were Moslem (of either Pakistani or Bangladeshi descent), but there were also Hindus and Christians. All were married and working class. Husbands were employed in local factories or on the buses; underemployed in family-run restaurants and shops; unemployed. Most of the women were recent migrants from rural areas; did not work outside the home and had limited contacts with non-Asian British people. Television, present in all the homes visited during fieldwork, was primarily used for the viewing of Hindi or Urdu videos. The use of medical services was therefore one of the few encounters they had with 'dominant' cultural values in British society.

The secondary method of data collection was interviews, primarily with the midwives, but also with a small number of other personnel, including hospital doctors and general practitioners, members of the local community health (CHC) and community relations (CRC) councils. The interviews were 'ethnographic' in character without a predetermined schedule but, instead, topics to be covered (Hammersley and Atkinson, 1983: 113). One of these topics was the midwives' attitudes to and perceptions of Asian women. Both directive and non-directive questions were used, although for the exploration of views about Asian women I favoured open-ended non-directive questions (Spradley, 1979). Questions used including the following: 'Would you say that there are different sorts/types of patients?' 'Are some women more difficult to care for?' 'Do some kinds of women have different needs?' There were two main types of interview. These may be characterised as *natural* and *formal* interviews.

The formal interviews with midwives were arranged in advance so that we would be able to talk at length. The *natural* interviews were interactions between myself and the midwives which occurred during observation, and in the context of general conversation. I took any opportunity to solicit accounts on the categories of interest, in particular views of black, and minority ethnic women. These occurred in the main with midwives I was shadowing when it was possible to introduce the topic with reference to individual Asian patients and/or particular events. Indeed it was often encounters with Asian women which would trigger expression of stereotyped views. For example, in the case of a woman who had a low haemoglobin count and had not taken her iron medication I asked the midwife why she thought this was, whether it was a common problem, and so on.

Altogether ten formal interviews were conducted, which varied in length between 30 and 60 minutes, and fifteen *natural* interviews of significant length. Many of the comments about Asian women came, however, in shorter natural interviews, for example during a woman's labour or between patients in the antenatal clinic. In addition I recorded comments from midwives and other actors during observation which may be regarded as unsolicited accounts. Responses and other accounts were recorded longhand almost invariably as they occurred. During observation I always had a notebook in my hand and so this was not problematic. The majority of the data for this paper come from the natural interviews, and from unsolicited accounts.

The midwives' stereotypes of the women

The stereotypes of Asian women have four main themes: the difficulty of communication; the women's lack of compliance with care and abuse of the service; their tendency to 'make a fuss about nothing'; their lack of 'normal maternal instinct'.

Communication difficulties The level of competence in English among the Asian women observed was generally low. This resulted in the women being characterised as unresponsive, rude and unintelligent. It also helped to strengthen the stereotypes because it was difficult for women with little English to make a personal relationship with the midwives and therefore challenge the assumptions made about them.

One or two midwives had extreme opinions and felt the women's lack of English to be a 'moral' failing. They articulated the view common among white people in Britain that immigrants should be competent in English. For example, during observation on the labour ward a staff midwife commented with reference to a woman who had been in the city for eight years that 'It's disgusting not to speak English after so long in Britain.'

None of the midwives in the hospital was of Asian descent and the hospital did not employ interpreters or advocates. Some staff reported this as a problem, others felt that such facilities were not necessary since there were Asian men employed in the hospital who could interpret if necessary. However, during the period of the study, no one was ever used in such a way. An extreme attitude was expressed by a consultant. Asked if the hospital was considering employing interpreters he answered:

Of course not. We haven't even got enough nurses. If you ask me they shouldn't be allowed into the country until they can pass an English exam.

Women who tried to speak English frequently offended the midwives. The main complaint was that the women did not say 'please' or 'thank you' and that they 'gave orders'. I know from my own attempts to learn Urdu that although the language has words equivalent to please and thank you, they are rarely used. In fact my Urdu teacher had to remind me frequently not to use them, pointing out that it was rather strange to use these words all the time 'like you English people do'. Instead in Urdu there is a polite form of the imperative with the 'please' built into the verb. The use of the imperative (fetch my baby, bring my lunch) without 'please' is indeed very rude in English, but was not so intended by the women.

Use of language indicates not only a person's attitudes towards those around them but also their intellectual abilities. The nature and content of speech (e.g. accent, vocabulary, grammar, syntax, dialect) are indicators employed to assess the other's competence. Black maternity patients in another study said that staff made them feel that they were 'too thick' to understand (Larbie, 1985: 19). In the present study some midwives described the Asian women as unintelligent. Commenting on their poor attendance at antenatal clinics (a part of the stereotype discussed below in the section on compliance with care) a clinic midwife remarked 'They're too stupid to remember when to come to the clinic.' One midwife remarked on Asian women's lack of intelligence in front of one, Asmat,⁴ who was in labour. The midwife had asked for permission to give her a vaginal examination and gained no response. She said:

Some Asian women are like blocks of wood, you know, thick [banging the side of her head]. Mind you others are delightful. It's impossible to know whether they've understood or not.

She used this as an example of how difficult it was to work with Asian women. Four other midwives told me that they found the women unrewarding to work with because they were unable to have a 'proper relationship' with them. Having a 'good relationship' with a mother was reported as an important part of a midwife's role.

The midwives were rarely motivated to take trouble with the women and to ensure that they understood. As a researcher I had far more time (and patience) to spend with individual women. For example with Asmat after the midwife had left I asked whether she had understood what had been said. She said that the midwives spoke too fast and were difficult to follow but she understood some of what they said. She had understood that the midwife thought that she was stupid. Many of the women in the sample said the same thing. They could understand a fairly simple conversation and would talk to me but not to the midwives.

Communication difficulties also stemmed from the use of colloquial language. It was common for staff to use culturally specific lay terms for symptoms and euphemisms for parts of the body which confused the Asian women. Terms such as 'waterworks', 'down there', 'the other end', 'tummy', and 'dizzy' are difficult even for those Asian women who are competent in English. Macintyre (1978) notes that in the antenatal clinic (and in other medical settings) staff modify their interactions with women according to the typifications made of them, based on such things as socioeconomic class, vocabulary and perceived intelligence. She argues that staff do this because they make the common sense assumption that standardised questions and vocabularies will not elicit standardised responses from patients in different categories. As she points out, the vocabulary used to those of low competence, social status and/or intelligence tends to be colloquial simplistic language. Ironically, these culturally specific terms were especially likely to be used with Asian women, who are of low status (by virtue of their ethnicity), were known to be of poor linguistic competence and perceived as being of low intelligence. This process can be seen in the following example.

I accompanied a community midwife on a home visit to a woman (Rubina). The midwife wanted to examine her to see if her fundus (i.e. uterus) had begun to contract back to its previous size. In order to do this examination properly (and to minimise discomfort) it is important that the woman's bladder is empty. Midwives therefore check with the woman first.

Midwife: Do you need to go to the toilet – pass water?

Rubina: Yes.

Midwife: Or have you just been?

Rubina: Yes.

Rubina looked confused and went out of the room, only to return immediately with an empty specimen bottle and an interrogative look on her face. The midwife waved it away crossly, told Rubina to lie on the sofa and began to feel her stomach.

While expansion of the question about 'going to the toilet' to include the phrase 'pass water?' in an interaction with an indigenous white English woman with limited vocabulary is probably better at eliciting a correct response than a question about 'urination', both versions may be equally incomprehensible to a woman who has English as a second language. [. . .]

Some of the misunderstandings between women and midwives can be attributed to differences in social and cultural background rather than the women's poor grasp of English. One area of confusion came over date of birth (DOB). Bureaucratic

records of all kinds rely on DOB for classification and filing purposes (e.g. social security records, passports, driving licences) and hospital records are no exception. For Asian women DOB is particularly important since (as described below) there was often confusion over their names, which did not fit the Western surname/first name categories.

At their first antenatal clinic visit all women have to give their DOB. For the majority of women this question was expected, understood, and easy to answer. Some of the Asian women, however, did not know their birth date (age and birthdays do not have social significance in South Asia as they do in Europe), and were unaware of why it mattered. Some of the midwives took this as another example of poor linguistic competence. For those who realised that the women understood, but could not answer the question, this lack of knowledge of what in western society is an everyday fact, and part of personal identity, was mystifying. This reinforced the view that the women were stupid (so stupid that they don't even know when their birthday is). Some of the women had solved the problem. They knew (or estimated) the year in which they were born. Telling officials the year only did not satisfy the bureaucratic requirements. Therefore they gave their DOB as the first of January that year. One midwife, in all innocence, remarked how surprising it was that 'all these women' are born on the first of January.

Lack of compliance with care and service abuse In interviews Asian women were described as non-compliant patients. Yet they were also (often simultaneously) characterised as service 'over-users' or even 'abusers'. Indeed in the midwives' accounts one often led to another. For example 'lack of compliance' with family planning advice led to increased fertility and therefore to 'over-use' and 'abuse' of the maternity service.

General examples of non-compliance given in interviews were that Asian women were poor attenders at antenatal clinics (cf. the clinic midwife's comment about women being 'too stupid' to know when to come, above) and did not go to parentcraft classes. Non-attendance could result from a variety of factors, including misunderstanding the date and time of the next appointment, and missing an appointment because of being called by the wrong name. Many of the Pakistani descent women gave the 'surname' Begum whereas Begum is a courtesy title, not unlike Mrs in English names (Henley, 1982). A woman called as 'Mrs Begum' would not immediately respond. This also contributed to the idea that the women were all alike: clinic midwives remarked that 'all these women have the same name'.

Another theme in the comments on non-compliance was that women had poor diets, suffered from anaemia and vitamin D deficiency and then failed to follow nutritional advice or take supplements. Few instances were actually observed in antenatal clinics. However, one community midwife shadowed was visiting an Asian woman daily to give her iron injections. The woman had previously been prescribed iron tablets but her haemoglobin count remained low. The midwife remarked:

These women are very irritating. They don't take the tablets and then have to have injections. It takes time and its not nice for them . . . they hurt these jabs.

Midwives gave the women's fertility as an example of service abuse. Larbie cites examples of black women in hospital being told they have too many children (Larbie, 1985: 19). In the present study a staff midwife on the postnatal nursing ward remarked of an Asian patient, 'She's having her ninth baby. It's a disgrace. Talk about abuse of the service.' Midwives argued that Asian women were not motivated

to use contraception. Discussing a woman on the postnatal ward a midwife remarked that her linguistic competence had disappeared when she had tried to talk to her about the topic. She told me that she had not pursued the point: 'She's not very interested in family planning is Mrs Begum.'

Several of the Asian women in the study had large families and women born in South Asia do have higher fertility than British born women (Diamond and Clarke, 1989). The only material in the hospital which was available in Asian languages was the information on Depo-Provera issued by the manufacturer. These were proudly shown to me by one of the consultants to demonstrate that he did take account of language problems.

Both midwives and doctors were ready to assume that Asian women have no interest in family planning. However, from the data collected in the separate sample of women³ I found that this was not always the case. In her small scale study of Pathan women in Bradford, Curren (1983) found that of the 17 questioned at least nine were using a method of contraception. Nevertheless the assumption persists. The following example shows the stereotype being employed in the face of communication difficulties.

During postnatal home visits midwives discuss plans for future birth control with new mothers. The following exchange occurred in an Asian's woman's home 5 days after the delivery of her son. The community midwife asked the Asian woman (Saida) about her intended family planning practice. The following conversation ensued:

Midwife: Do you want any more children?

Saida: [confusion]

Midwife: You know, any more babies?

Saida: Four children

Midwife: More babies? Do you want to have five babies?

Saida: Not five babies, four babies.

Midwife: Well go and see Dr Smith in five weeks with your husband and discuss not having any more babies.

The midwife did not pursue the point any further. Saida appears to be answering the question of 'how many children do you have?' rather than 'how many children do you want?' Neither I nor the midwife could be certain either way. After we left the midwife told me that she tried her best with encouraging family planning but 'these women are just not interested'.

Not all the Asian women in the study were opposed to fertility control. In an antenatal clinic a consultation was observed between an obstetric senior house officer (SHO) and an Asian couple with one child of under one year and a second unwanted pregnancy. The referral letter from the woman's GP stated that she had been on the pill but had stopped taking it because of breakthrough bleeding. The GP pointed out in the referral letter that the pregnancy was the couple's fault: she had stressed that the husband must use a sheath and yet they had failed to comply with this advice. The SHO asked the husband about this and he said that he did not like the sheath. Both the doctor and midwife told me that they thought this couple were being unnecessarily difficult about the pregnancy. The SHO remarked, 'It's only her second baby. I thought these people liked large families.' The possibility of a termination was not discussed.

The second main issue which was cited in connection with 'service abuse' was circumcision, which was not provided on the NHS in the study hospital. One Asian

couple observed had just had a second son. The first had been delivered in the hospital and circumcised, but they had not paid the bill for the operation. The ward sister told the father that this time he must pay in advance. He was not pleased, but paid up. A staff midwife told me that she was glad that they had been made to pay:

These people will try anything. He tried to tell me that he didn't understand that he had to pay, but he knew full well. He was just trying it on.

A second midwife remarked:

I'm sympathetic but I get fed up with the repeated abuse of the service by these people.

This unwillingness to pay was not common to all Asian couples. In another case, a paediatrician apologised to a father for the charge, and remarked that he thought it was discriminatory. The father disagreed and said that he was quite happy to pay:

I am a guest in this country. This country has been very good to me, why shouldn't I pay if I want something different?

The debate became quite heated with the doctor and a midwife arguing with the father over whether or not he should have to pay. The paediatrician thought that circumcisions should be available in all health districts on the NHS. In addition to the fact that he thought that it was racist (because particular religious groups including Moslems have their sons circumcised) he had seen the results of circumcisions by traditional practitioners which had ended up in the accident and emergency department.

Associated with comments about service abuse, midwives reported that Asian women were demanding and complaining. During interviews with midwives on postnatal nursing wards a major complaint was that Asian women refused to be physically active after delivery of their babies and, a lesser complaint, did not do the recommended toning exercises. A quotation from one midwife which illustrates an extreme of this view is that the women just 'lie in bed all day and expect to be waited on hand and foot'. [. . .]

Making a fuss about nothing 'Making a fuss about nothing' was a phrase which recurred in interviews and was particularly applied to the intra- and postnatal behaviour of women. This view of black women has been reported in other studies. Larbie (1985: 22) found that black women were told by staff that they make too much noise when in pain or discomfort. Brent Community Health Council (1981: 13) reports the stereotype of black people having a low pain threshold and Rakusen (1981: 81) mentions this specifically with reference to Asian women. Homans and Satow (1982: 17) note that some health workers hold the belief that black patients are likely to 'make a fuss about nothing' and suggest that this will limit the health workers' willingness to try to communicate effectively with such patients.

In the present study Asian women were characterised as 'attention seeking'; making too much noise and 'unnecessary fuss' during labour (because of 'low pain thresholds') and constantly complaining of minor symptoms (particularly headaches) in the postnatal period. The issues of noise during labour and low pain thresholds were mentioned in interviews by all the midwives who worked on the labour ward. In response to a question about whether there were different sorts of patients who

needed different sorts of treatment a typical response (from a labour ward midwife) was:

Well, these Asian women you're interested in have very low pain thresholds. It can make it very difficult to care for them.

Six Asian and four white women's deliveries were observed. None of the Asian women made a great deal of noise or had pain control and yet one of the white women had pethidine and another an epidural for pain (although this latter case was a premature labour of an older and very frightened woman). It may be that this was partly observer effect. Two of the husbands of Asian women thanked me for being with their wives during labour because it had stopped them being frightened. One midwife noted that women who are frightened make noise:

We perceive Asian women as whinging when they are just frightened. They just make more noise than we do.

This shows that it is possible to hold a stereotyped view without necessarily being unsympathetic to the stereotyped group.

Despite the fact that there was variation between women (and that non-Asian women also make a noise in labour) midwives saw making a noise in labour as the norm (although deviant behaviour) for Asian women. One woman (Shakila), expecting her eighth baby, had a long induced labour during which she vomited several times. On the postnatal ward she complained of a sore throat. The midwife said:

I expect you were shouting a lot during labour. That's why your throat hurts.

I had been with the woman in labour and said that actually this was not the case. The midwife then went on to report a story to me which was the exception which proves the rule:

I have a friend who's a Moslem. She's a GP's wife. She had a section and she had a lot of pain. But you know how much fuss they make. No one took very much notice. But I knew her so I knew that it really hurt. I made sure she got taken seriously.

This example provides circumstantial evidence that ethnicity is more important than class in the framing of typifications.

The noise Asian women were reported to make in labour was considered doubly inexcusable because they were perceived to have easier deliveries than Caucasian women. Some midwives cited this as a major (ethnic) difference. Others (and doctors I spoke to) pointed out that length of labour was primarily affected by parity (i.e. number of previous deliveries). Asian women have higher fertility and therefore make up a large proportion of the women of high parity delivered in maternity hospitals. For many of the midwives, however, ethnicity became the overriding factor. This is illustrated in the following example from my field notes. I was looking for an Asian woman on the antenatal nursing ward and a midwife told me that she had gone down to the labour ward. She was being induced and it was her first baby. Nevertheless the midwife remarked 'Oh, she'll be back in an hour, they're always quick.' In the event the woman had a slow and long labour. This example further demonstrates how a woman's ethnicity becomes her master status.

The midwife knew that it was an induction and a first baby, both factors which indicated a longer labour, and yet the woman's ethnicity was seen as the overriding factor.

On the postnatal ward the Asian women were unwilling to get up and therefore the midwives had to nurse them in bed. This made them unpopular. The following comments from a midwife were overheard in the ward coffee room:

Mrs Kajoo is being difficult again. She wants me to bring her bottle [for the baby] but I'm not doing it. They're always ordering us around. Bring me my bottle indeed. [To a second midwife]. You're not to do it either.

Community midwives too cited examples of women 'making a fuss about nothing'. In the coffee room in the GPU two community midwives were discussing a woman who had been discharged from postnatal midwifery care. One midwife remarked to the other:

I went to see Mrs Iqbal yesterday and finally got rid of her. She didn't want to be discharged . . . said she'd got a headache. These women they make such a fuss. In their own culture they get so much attention they have to invent it. I think it's pathetic.

Lack of normal maternal instinct A theme running through accounts of Asian women given by midwives was that 'they're not the same as us'. In particular they were described as lacking normal maternal instinct and feelings. This was in part attributed to their large numbers of children and 'unhealthy' preference for sons.

In the everyday world in our society there is a concept of 'maternal instinct' which implies that humans (especially women) have instinctive drives towards reproduction. Macintyre (1976: 151-2) has pointed out that this and other aspects of 'normal' reproduction are socially constructed. However, she argues that although the majority of sociologists recognise the social construction of reproduction, most studies have defined 'normal' reproduction as occurring exclusively inside the statistically common nuclear family unit. The household formation (and different attitudes to marriage) of many Asian families (A. Shaw, 1988) puts them outside this Western normality. A more recent analysis of the psychological research into motherhood notes that the construction of 'normal' motherhood is based on white middle class behaviours (Phoenix and Woollett, 1991). Psychological studies have omitted black and working class mothers from studies of normal processes, but included them in studies of deviance. Phoenix and Woollett (1991) argue that the narrow focus of these studies has helped to maintain negative social constructions of black mothers (1991: 25). In addition, mothers from minority ethnic groups are themselves socially constructed as 'other' and hence by definition viewed as deviating from 'good/normal' mothering (1991: 17).

Thus constructions of normal reproduction and motherhood take no account of structural differences between mothers. Some of the Asian women's behaviours did not conform to the prevailing (Western) model of motherhood. For example, of the six South Asian women observed during labour, two reacted badly when the midwives delivered their baby onto their stomach, and three did not want to hold their newborn baby straight away. All those observed did not want to breastfeed immediately after delivery, and the majority of women in the study were likely to choose to bottle feed. Midwives were also upset by the preference for sons expressed by women (and related to the importance of male offspring in Islamic culture). Some of the women's behaviours could be interpreted positively in the

light of dominant models: for example, none of the women in the sample worked outside the home, none smoked. However not one midwife mentioned this as a positive characteristic of Asian women although these issues were discussed with reference to mothers in general.

Models of childbirth and motherhood vary by culture. Many of the behaviours described above do not conflict with the South Asian Islamic models of motherhood described in Curren's (1983) study of Pathan women in Bradford. However, they caused midwives, with their different cultural perspective, to characterise women as lacking normal maternal instinct and feelings.⁵

Discussion

The examples above demonstrate how individual women's behaviours were interpreted within the stereotypes of 'Asian women' held by the midwives. This is not surprising since typifications of patients are common in medical settings. Menzies' (1960) classic paper on the defence against anxiety among nurses gives some indication of why this should be. She argues that depersonalisation and categorisation of patients (as, for example, bed numbers or illnesses) reduces the possibility of emotional attachment between carer and patient, and thus reduces anxiety and stress for the former. Green et al. (1990: 125) write that midwives on the labour ward commonly use stereotypes 'to make assumptions about what a particular woman is likely to want in labour and delivery'. In the present study midwives also used stereotypes to make judgements about the kind of care women deserved. When a woman speaks little English, stereotypes will be particularly likely to be employed in this way by the midwives.

The practice of typification described by Menzies leads to staff forming, transmitting and accepting stereotyped views of certain groups. For example the 'well-educated middle-class National Childbirth Trust type' or the 'uneducated working class woman' (Green et al., 1990), 'the demanding Jew' and the 'difficult Asian woman'. If an individual patient is easily categorised as a member of such a group she is more likely to suffer the effects of negative stereotyping. Black and minority ethnic women are particularly vulnerable to such typification because the colour of their skin makes it easy for staff to 'recognise them' and to assign them to a (negatively typified) group. 'Communication difficulties' were a major theme of the 'Asian' stereotype. The negative typifications were reinforced if women had poor English because midwives could more readily apply stereotypes to women with whom they could not communicate. Furthermore, women were unable to challenge the view that 'they're all the same'.

Communication difficulties: linguistic and cultural differences Communication difficulties occur at two levels: the linguistic and the cultural. As demonstrated in the examples above, language is a problem for some women. Their lack of English infuriated the midwives, and was one of the main 'problems with Asian women' mentioned by staff. More importantly, lack of English made the experience of hospital mystifying and often frightening for the women. However, language was not the sole cause of misunderstanding. Even women who spoke good English experienced culturally based communication difficulties.

Schutz (1976: 95) discusses the difficulty of the 'stranger', particularly (although not exclusively) an immigrant to a country, trying to interpret the cultural pattern

of a social group which she or he approaches. He argues that the 'approached' (i.e. dominant) group has a system of knowledge, albeit 'incoherent, inconsistent and only partially clear', which allows anybody a reasonable chance of understanding and being understood. He describes this in terms of 'recipes' for interpreting the social world and expressing oneself within it. Garfinkel paraphrases this as 'common sense knowledge of social structures' (Garfinkel, 1967: 76). The stranger does not share the dominant recipes for communication. [. . .]

Applying these arguments to a medical setting, Hughes (1977) examines the way in which doctors in a casualty department use everyday knowledge to categorise patients: those needing immediate care; those who can wait; those who are deviant (drunk, down and out) and so on. He observed that overseas doctors had difficulty in typing patients and suggests that this may stem from their lack of 'conventional knowledge' (as opposed to medical expertise). It is possible to reverse this argument and to say that one reason why first generation black patients may become negatively typified is a result of the same phenomenon: they lack conventional 'common sense' knowledge about the system.

Ardener (1972, 1975, 1989) has discussed (with particular reference to the accounts of women rendered by (male) anthropologists in their monographs) how a subordinate group may become 'muted' in interactions with the dominant order. He argues not that they are dumb, but that when such groups become incorporated into dominant models and have to speak using dominant modes of expression then their meanings may become lost. They are muted because they are not listened to, or if listened to, not understood. Of course this argument can apply to all women using the maternity services: the dominant mode of expression is medical. However, black and minority ethnic women will be doubly muted because they will be dealing with two degrees of dominance: the white British and the male medical. [. . .]

Asian women as 'bad' patients Stereotyping can be seen in the context of the research on patient typification (see Kelly and May, 1982 for a detailed review). The characteristics of Asian women included in the midwives' stereotypes echo the negatively typified characteristics cited in this literature. In addition, the women's ethnicity (which was never cited as a negative characteristic: no midwife told me that she didn't like black people) almost certainly plays a direct role in their typification as 'bad' patients.

Race, ethnicity and nationality have several effects. Patients who are not Caucasian, born outside Britain and who have poor command of English are likely to be unpopular. Several authors (Brown, 1966; Papper, 1970; Stockwell, 1972) cite these characteristics as leading to negative client assessment by health professionals. In addition, a patient's ethnicity makes her more likely to be classified as an undesirable patient because her knowledge and expectations of the medical services are different to those of indigenous patients. Goffman (1969: 366), in his analysis of the sick role, writes that the proper enactment of this role involves a characteristic etiquette, for example entailing (in Western culture) the belittling of discomfort, physical cooperation with carers and proper presentation of self. He notes that there are 'appreciable ethnic differences in the management of the sick role'.

There is evidence that patients become unpopular if they are perceived as constantly complaining (Armitage, 1980; Lorber, 1975; Stockwell, 1972); malingering; and receiving treatment under false pretences (Kelly and May, 1982). Those who fail to conform to the clinical regime are also regarded unfavourably (Basque and Merige, 1980; Gillis and Biesheuvel, 1988; Spitzer and Sobel, 1962).

A theme running through the data reported above is the role of communication difficulties which may be seen as a major factor in negative typification of Asian women. Because of these problems it can be more difficult and time consuming for midwives to care for them. Menzies (1960) leads us to expect that patients who cause a high level of anxiety or who cause staff to feel ineffective or angry (such as women who cannot communicate to staff that they are all right) may become negatively typified. This is supported by other studies (e.g. Gillis and Biesheuvel, 1988; Holderby and McNulty, 1979; Orlando, 1961; Schwartz, 1958; Ujhely, 1963). In addition, Kelly and May (1982) point out that some patients are defined as difficult because they hinder staff in their work. Finally, perceived patient intelligence has been shown to influence staff's evaluation of them (Gillis and Biesheuvel, 1988; MacGregor, 1960; Papper, 1970).

Accepting a rigid stereotyped view of Asian women may act as a defence against the anxiety generated in staff who cannot communicate with them. Stereotyping can allow staff to make assumptions about the care women need (or deserve). In the context of the present study, a midwife does not need to feel too anxious about the noise an Asian woman makes in labour because, according to the stereotyped view such women have 'a low pain threshold' and therefore do not need pain relief. In addition they 'make a fuss about nothing' and so do not deserve it either. Asian women's problems with English become part of the stereotype and so staff's willingness to try to communicate with them is reduced.

There is a second set of explanations for the prevalence of stereotyping associated with the different attitudes and behaviour (real or perceived) of the women. Several authors note that patients who are judged to be attention-seeking (Gillis and Biesheuvel, 1988; Jeffery, 1979; Lorber, 1975; MacGregor, 1960); demanding (Brown, 1966; Gillis and Biesheuvel, 1988; Jeffery, 1979; Papper, 1970; Schwartz, 1958); or who are thought to disrupt clinical routine unnecessarily (Lorber, 1975; Orlando, 1961) are negatively typified by staff. Those who are seen as manipulative (Armitage, 1980; Ujhely, 1963) are particularly unpopular. [. . .]

As Murcott emphasises, when typifying patients 'staff's concerns with getting through the day's work are of more immediate relevance than general moral concerns' (Murcott, 1981: 129). Second, and more subtly, women are unpopular if they prevent the midwives from fulfilling their role. This includes everything from carrying out their work well to feeling positive about themselves. Once a midwife has had several difficult encounters with women of Asian descent it is not surprising if, by virtue of their visibility, all Asian women become perceived by her as 'difficult patients'. In this way stereotypes form and are transmitted to other staff. [. . .] For black and minority ethnic women their moral status may (for some staff) be already compromised because they are black. Racist attitudes are not unknown among health service staff (Brent Community Health Council, 1981; Larbie, 1985; Phoenix, 1990). Midwives could employ a stereotype to allow them to practise discrimination based on ethnicity without having to admit that to themselves, or appearing to others to be racist.

The effect of stereotypes The data demonstrate the presence and construction of stereotypes of Asian women, but it is beyond the scope of the study to investigate fully their effect. The data strongly suggest that women are disadvantaged by the assumptions made about them by midwives. The two clearest cases concern family planning and pain control. In the examples of Mrs Begum and Saida neither midwife endeavoured to overcome language difficulties and talk about fertility control

because they 'knew' that the women were not interested. Yet the example of the young couple with the unwanted pregnancy shows that this assumption should not be made. In that case it cannot be known whether termination would have been discussed with a similar white British couple.

None of the six Asian women observed during labour was offered pain control other than gas and air. Of the four white women observed two had intervention to control their pain. The sample is not matched and so no direct comparison is possible. The only indication is that in the case of Shakila, who suffered a long and painful labour, the registrar who saw her several hours after induction told me that pethidine could not be given because it was too close to the delivery. In the cases of the white women who had pain control this was at the suggestion of a midwife. The midwife looking after Shakila, who could have offered pethidine at an appropriate time, did not.

Stereotypes of Asian maternity patients, and black and ethnic minority patients generally, cannot be dissociated from the racist attitudes of many white people in Britain (one-third of the sample in the 1984 *British Social Attitudes* survey admitted to being racially prejudiced; Jowell and Airey, 1984). Space does not allow for a discussion of how the midwives' stereotypes reflect or feed into racist discourse but the following point can be made. Although it cannot be known whether the midwives were consciously or overtly racist any stereotype based on a racial or ethnic group is discriminatory, regardless of the stated attitudes of those holding the view.

Conclusion

This analysis has revealed several different ways in which stereotypes affect the interaction between staff and women, and how this interaction can reinforce the negative views of women. [. . .]

Individuals are typed according to a variety of criteria, cited in the literature review above. Macintyre (1978: 599) notes that staff revise their typification in the light of interactions with patients. It is difficult for women to assert their 'moral status' (and so get the typification revised) because language difficulties and cultural differences make it hard for them to make individual relationships with midwives.

There is evidence that ethnicity is a powerful criterion for typification, made stronger by its very visibility. Jeffery (1979: 90) shows how certain sorts of patients are unable to achieve entry into the legitimate career of sickness. The stereotypes emphasised the deviance of Asian women. If it is the women's ethnicity which causes them to be negatively typified then they are being disadvantaged because of ascribed ethnicity and not on the basis of individual action.

This analysis has implications for 'cultural awareness training' which can lead to static stereotyped views. It can encourage staff to make assumptions about ethnic difference based upon physical (racial) difference. If an Asian woman makes a noise in labour this is not because she is in pain but because Asian women in general have low pain thresholds and make fuss about nothing. There is therefore a difference in kind between stereotypes of black women and those of white women based on class. Race is a very hard boundary to cross. Stereotypes of Asian women can be applied purely on the basis of physical appearance and are therefore potentially racist.

A midwife in the present study asked me if I could recommend some information to help her understand her Asian patients. I suggested the booklets by Alix Henley (e.g. Henley, 1982, *Caring for Muslims and Their Families*). The midwife looked surprised

'I don't have time to read books,' she said, 'What we need is an A4 bit of paper with it all on so we can look things up when we need them.' This attitude to ethnicity is that all we need is some kind of cultural recipe book. Her reaction is similar to that of many health professionals to the complexities of other ethnicities: they're different to us (we need a map) but they're all the same (so one map will do).

Midwives were inclined to accept a view of 'Asian women' as a homogeneous group. In fact they were heterogeneous, not only in their cultural and religious background, but also in their relationships with staff. In other words the midwives held a rigid homogeneous view of these women, based on their physical appearance, in a way they did not for white British women. The behaviours and characteristics which led to negative typification of the women by midwives were not, therefore, common to all women of Asian descent. However characteristics of some women led to a stereotyped view which was attached to all women who were (or, more significantly, looked as if they were) of 'Asian' ethnic origin. As Phoenix (1990: 228) writes, 'The propensity to see black women as being "all the same" is not only inaccurate but also racially discriminatory in that it can mask individual black women's needs.'

Notes

- 1 Women are booked for care with a consultant obstetrician and delivered in the hospital labour ward. However, their routine antenatal checks are carried out by their GP and community midwife, i.e. the antenatal care is shared. This compares with GP directed care where all care is community based and the woman is delivered by community midwives in the General Practitioner Unit.
- 2 Estimated by the city council. The 1981 census did not collect data on ethnic origin, data from the 1991 census is not yet available.
- 3 This study is part of a wider project which also included a separate study of South Asian descent women who were recruited from an English language class and by snowball sampling. It is from this second study that the background information on the Asian women is derived.
- 4 Asmat is a pseudonym, as are all other names of respondents.
- 5 For a more detailed analysis of these issues see Currer (1983), Donovan (1986), Homans (1980)

References

- Ardener, E. (1972) Belief and the problem of women. Reprinted in Ardener, S. (ed.) (1975) *Perceiving Women*. London: Dent.
- Ardener, S. (1975) The problem of women revisited. In Ardener, S. (ed.) (1975) *Perceiving Women*. London: Dent.
- Ardener, E. (1989) *The Voice of Prophecy* (edited by Malcolm Chapman). Oxford: Blackwell.
- Armitage, S. (1980) Non-compliant recipients of health care. *Nursing Times Occasional Papers*, 76, 1.
- Basque, L.O. and Merige, J. (1980) Nurses' experiences with dangerous behaviour: implications for training. *J. Continuing Education in Nursing*, 11, 47-51.
- Brent Community Health Council (1981) *Black Women and the Maternity Services*. London: Brent Community Health Council.
- Brown, E.L. (1966) Nursing and patient care. Reprinted in Davis, A. (ed.) (1978) *Relationships between Doctors and Patients*. Farnborough: Saxon House.
- Coleman, D.A. and Salt, J. (1992) *The British Population*. Oxford: Oxford University Press.

- Currer, C. (1983) *The Mental Health of Pathan Mothers in Bradford: A Case Study of Migrant Asian Women*. Coventry: University of Warwick.
- Diamond, I. and Clarke, S. (1989) Demographic patterns among Britain's ethnic groups. In Joshi, H. (ed.) (1989) *The Changing Population of Britain*. Oxford: Blackwell.
- Donovan, J. (1986) *We Don't Buy Sickness It Just Comes*. Aldershot: Gower.
- Garfinkel, H. (1967) *Studies in Ethnomethodology*. Englewood Cliffs, NJ: Prentice-Hall.
- Gillis, L. (with Biesheuvel, S.) (1988) *Human Behaviour in Illness*. London: Faber & Faber.
- Gilroy, P. (1987) *There Ain't No Black in the Union Jack*. London: Hutchinson.
- Goffman, E. (1969) The insanity of place. *Psychiatry*, 32, 357-87. Reprinted in Black, N. et al. (eds) *Health and Disease: A Reader*. Milton Keynes: Open University Press.
- Green, J. et al. (1990) Stereotypes of childbearing women: a look at some evidence. *Midwifery*, 6, 125-32.
- Hammersley, M. and Atkinson, P. (1983) *Ethnography: Principles in Practice*. London: Tavistock.
- Henley, A. (1982) *Caring for Muslims and their Families: Religious Aspects of Care*. Cambridge: National Extension College.
- Holderby, R.A. and McNulty, E.G. (1979) Feeling feelings: how to make a rational response to emotional behaviour. *Nursing*, October, 39-43.
- Homans, H. (1980) *Pregnant in Britain. A Sociological Approach*. Unpublished PhD thesis: University of Warwick.
- Homans, H. and Satow, A. (1982) Can you hear me? Cultural variations in communication. *J. Community Nursing*, January pp. 16-18.
- Hughes, D. (1977) Everyday medical knowledge in categorising patients. In Dingwall, R. et al. (eds), *Health Care and Health Knowledge*. London: Croom Helm.
- Jeffery, R. (1979) Normal rubbish: deviant patients in casualty departments. *Sociology of Health and Illness*, 1, 90-107.
- Jowell, R. and Airey, C. (1984) *British Social Attitudes*. London: Gower.
- Kelly, M.P. and May, D. (1982) Good and bad patients: a review of the literature and a theoretical critique. *J. Advanced Nursing*, 7, 147-56.
- Larbie, J. (1985) *Black Women and the Maternity Services*. London: Training in Health and Race.
- Lorber, J. (1975) Good patients and problem patients: conformity and deviance in a general hospital. *J. Health and Social Behavior*, 16, 213-25.
- MacGregor, F. (1960) *Social Science in Nursing: Applications for the Improvement of Patient Care*. New York: Russell Sage.
- Macintyre, S. (1976) 'Who wants babies?' The social construction of 'Instincts'. In Leonard, D.L. and Allen, S. (eds), *Sexual Divisions and Society: Process and Change*. London: Tavistock.
- Macintyre, S. (1978) Some notes on record taking, and making in an antenatal clinic. *Sociological Review*, 26, 595-611.
- May, D. and Kelly, M.P. (1982) Chancers, pests and poor wee souls: problems of legitimation in psychiatric nursing. *Sociology of Health and Illness*, 4, 279-300.
- Menzies, I.E.P. (1960) A case study in the functioning of social systems as a defence against anxiety. A report on a study of the nursing service of a general hospital. *Human Relations*, 13, 95-121.
- Murcott, A. (1981) On the typifications of 'bad' patients. In Atkinson, P. and Heath, C. (eds) (1981) *Medical Work: Realities and Routines*. London: Gower.
- Orlando, I. (1961) *The Dynamic Nurse-Patient Relationship: Function, Process and Principles*. New York: G.P. Putnam's Sons.
- Papper, S. (1970) The undesirable patient. *J. Chronic Diseases*, 22, 777-9.
- Pearson, M. (1986) The politics of ethnic minority health studies. In Rathwell, T. and Phillips, D. (eds), *Health, Race and Ethnicity*. Beckenham: Croom Helm.
- Phoenix, A. (1990) Black women and the maternity services. In Garcia, J. et al. (eds), *The Politics of Maternity Care: Services for Childbearing Women in Twentieth-Century Britain*. Oxford: Clarendon Press.
- Phoenix, A. and Woollett, A. (1991) Motherhood: social construction, politics and psychology. In Phoenix, A. et al. (eds), *Motherhood: Meanings, Practices and Ideologies*. London: Sage.
- Prottas, J.M. (1979) *People-Processing*. Lexington MA, USA: Lexington Books.

- Rakusen, J. (1981) Depo-Provera: the extent of the problem. A case study in the politics of birth control. In Roberts, H. (ed.), *Women, Health and Reproduction*. London: Routledge & Kegan Paul.
- Rathwell, T. (1984) General Practice, ethnicity and health services delivery. *Social Science and Medicine*, 19, 123-30.
- Schutz, Alfred (1976) The stranger: an essay in social psychology. In Schutz, A. *Collected Papers II. Studies in Social Theory* (edited by Arvid Brodersen). The Hague, Netherlands: Martinus Nijhoff.
- Schwartz, D. (1958) Uncooperative patients? *Am. J. Nursing*, 58, 75-7.
- Shaw, A. (1988) *A Pakistani Community in Britain*. Oxford: Basil Blackwell.
- Shaw, C. (1988) Components of growth in the ethnic minority population. *Population Trends*, 52, 26-30.
- Spradley, J.P. (1979) *The Ethnographic Interview*. New York: Holt, Rinehart & Winston.
- Spitzer, S. and Sobel, R. (1962) Preferences for patients and patient behaviour. *Nursing Research*, 11, 233-5.
- Stockwell, F. (1972) *The Unpopular Patient*. Royal College of Nursing Research project. Series 1 no 2. London: Royal College of Nursing.
- Ujhely, G.B. (1963) *The Nurse and her Problem Patient*. New York: Springer Verlag.

What you might do now

