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**PARENTAL UTILISATION OF CHILD MEDICAL CARE: A  
GROUNDED THEORY APPROACH**

A thesis presented in partial fulfilment of  
the requirements for the degree of Doctor of Philosophy  
in Psychology at Massey University

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***Melanie F Martin***

**2002**

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**SUPERVISOR'S DECLARATION**

This is to certify that the research carried out for the Doctoral thesis entitled "Parental Utilisation of Child Medical Care: A Grounded Theory Approach" was done by Melanie Martin in the School of Psychology, Massey University, Turitea Campus, New Zealand. The thesis material has not been used in part or in whole for any other qualification, and I confirm that the candidate has pursued the course of study in accordance with the requirements of the Massey University regulations.

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Date *1/12/03*



**CANDIDATE'S DECLARATION**

This is to certify that the research carried out for my Doctoral thesis entitled "Parental Utilisation of Child Medical Care: A Grounded Theory Approach" in the School of Psychology, Massey University, Turitea Campus, New Zealand is my own work and that the thesis material has not been used in part or in whole for any other qualification.

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**ABSTRACT**

Within New Zealand, child medical care use is a prevalent source of concern with current medical care utilisation rates considered inadequate to achieve optimal child health. Although previous research into child medical care use has made a valuable contribution to understanding in this area, such research is plagued by various limitations that indicate the need for further research adopting a different approach. This study draws on a social constructionist perspective and grounded theory methods to investigate parents' talk surrounding child medical care use. The study investigates how parents construct their seeking treatment and prevention of childhood illness and disease from a medical practitioner or nurse looking at, in particular, seeking medical treatment for childhood illness, the use of Well Child checks, and childhood immunization. Individual semi-structured interviews were conducted to explore how parents construct the complex process of child medical care use. The findings indicate that child medical care use, in the form of treatment-seeking and the utilisation of Well Child services, is constructed as two distinct but similar processes. Generally, the findings demonstrate that such child medical care use comprises parents constantly negotiating various issues and concerns characterised by tension, conflict, and dilemma. These

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issues and concerns consist of doing the 'right' thing, the risk of medicines and immunisations, practical barriers to seeking care, competing demands and priorities, and social expectations and social pressure. These issues and concerns arise - and are resolved - within the wider context of parents trying to be 'good parents', trying to preserve child health (not just treat illness), the immediate environment surrounding treatment-seeking, parents trying to fulfil social roles - and individual and socially shared understandings of, for example, medicines. More broadly, child medical care use is conceptualised as a socially based decision-making process that takes place within a social context in which child health, illness, and disease are medicalised, and within which parents are trying to do the right thing for the child. The findings from this study contribute to knowledge and understanding in this area in a number of ways. These are discussed, along with the implications of these findings, and recommendations for future research are made.

## ACKNOWLEDGEMENTS

I would like to thank my supervisors Associate Professor Kerry Chamberlain and Dr Christine Stephens for their encouragement, advice, and constructive criticism throughout this research.

I also wish to acknowledge those who agreed to participate in this research. My special thanks goes to them for generously sharing their experiences and thoughts. Your contribution has been invaluable.

I would like to extend my thanks to the Health Research Council of New Zealand for providing the financial support that has assisted me in my academic development.

Finally, I would like to thank my friends and family who acted as a great source of support and encouragement throughout this project. I would especially like to thank you for having a great sense of pride and belief in me.

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**UTILISATION OF CHILD MEDICAL CARE: A GROUNDED THEORY  
APPROACH**

**TABLE OF CONTENTS**

ABSTRACT	ii
ACKNOWLEDGEMENTS	iv
TABLE OF CONTENTS	vi
LIST OF FIGURES	ix
<b>CHAPTER ONE: THESIS OVERVIEW</b>	<b>1</b>
<b>CHAPTER TWO: EXAMINING CHILD HEALTH IN NEW ZEALAND</b>	<b>5</b>
<b>CHAPTER THREE: RESEARCHING CHILD MEDICAL CARE USE</b>	<b>16</b>
CONSIDERING LAY UNDERSTANDINGS	17
ACCOMMODATING A DIVERSITY OF PROCESSES	21
THE IMPORTANCE OF CONTEXT	24
ACCOMMODATING PROCESS	28
THE NEED FOR AN OPEN AND FLEXIBLE APPROACH	32
<b>CHAPTER FOUR: A GROUNDED THEORY APPROACH</b>	<b>37</b>
PHILOSOPHICAL ASSUMPTIONS	41
GROUNDED THEORY FEATURES AND PROCEDURES	49
<b>CHAPTER FIVE: THE RESEARCH PROCESS</b>	<b>66</b>
USING GROUNDED THEORY	66
SELECTION AND RECRUITMENT OF PARTICIPANTS	68
DATA COLLECTION	71
ETHICAL CONSIDERATIONS	76

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OVERVIEW OF THE DATA ANALYSIS	79
 <b><u>FINDINGS:</u></b>	
<b>CHAPTER SIX: CONSTRUCTIONS SURROUNDING THE UTILISATION OF CHILD MEDICAL CARE</b>	<b>87</b>
CONSTRUCTING CHILDREN	88
CONSTRUCTING THE PARENTING ROLE AND THE "GOOD PARENT"	93
CONSTRUCTING THE MEDICAL PROFESSION	99
CONSTRUCTING CHILDHOOD ILLNESS AND DISEASE	105
CONSTRUCTING MEDICINES	114
 <b>CHAPTER SEVEN: CONSTRUCTING THE UTILISATION OF CHILD MEDICAL CARE: SEEKING CARE</b>	
DOING THE "RIGHT" THING	127
LIMITING RISK	135
DEALING WITH ROLE CONFLICT AND BARRIERS TO CARE	143
CHAPTER DISCUSSION	147
 <b>CHAPTER EIGHT: CONSTRUCTING THE UTILISATION OF CHILD MEDICAL CARE: SEEKING HEALTH PRESERVATION</b>	
DOING THE "RIGHT" THING	155
LIMITING RISK	164
CHAPTER DISCUSSION	173
 <b>CHAPTER NINE: GENERAL DISCUSSION</b>	
GENERAL OBSERVATIONS	181
RESEARCH AND PRACTICE IMPLICATIONS	192
MOVING FORWARD: FUTURE RESEARCH DIRECTIONS	199

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<b>REFERENCES</b>	<b>207</b>
<b>APPENDICES</b>	
APPENDIX A: INVITATION LETTER	233
APPENDIX B: INFORMATION SHEET	234
APPENDIX C: CONSENT FORM	236

**LIST OF FIGURES**

<b>Figure</b>		<b>Page</b>
Figure 1	Schematic representation of the process of treatment-seeking	152
Figure 2	Schematic representation of the process of seeking health preservation	179

**CHAPTER ONE****THESIS OVERVIEW**

The present study was developed from the understanding that the status of child health in New Zealand is an issue of concern, and that there is a need for more detailed research into child medical care service use within New Zealand to provide a basis from which to improve this status. It was also developed from the understanding that previous research into child medical care use is plagued by limitations that impact upon the understanding that can be obtained regarding child medical care use. More specifically, the objectives of this investigation are to examine and explore parents' talk regarding seeking and utilizing treatment and prevention for childhood illness and disease from a medical practitioner or nurse, and to fill the gaps in current understanding in this area. In particular, this study looks at seeking medical treatment for childhood illness, the use of Well Child checks, and childhood immunization.

The issue of child medical care use within New Zealand is identified in Chapter Two and an argument is provided for the need for further research in this area.

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Within this chapter an outline of the importance of child health and an examination of current child health statistics and concerns within New Zealand establish child health care use as an area in need of investigation.

Previous research into child medical care use has made a valuable contribution to understanding in this area. However, Chapter Three presents a critical review of this research claiming that it has tended to adopt an approach to investigating child medical care use that fails to consider lay understandings, ignores the diversity of processes involved, downplays contextual information, produces a static conceptualisation of child medical care use, and approaches such investigations in a restricted manner. This discussion provides a critical introduction to the need for a different approach to investigating child medical care use that addresses these limitations and thus furthers understanding in this area. It is suggested that this can be achieved with the use of grounded theory methods.

Chapter Four outlines the philosophical stance within which the present study was conducted; this being a version of a social constructionist approach that unites a realist ontology and the epistemology of constructionism. Following this is a discussion of the particular features and procedures of grounded theory methodology that are valuable for - and provide a powerful means of - investigating child medical care use within the aims of the present study. These features and procedures are outlined along with the issues surrounding them

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and my positioning regarding these issues, from the social constructionist stance adopted.

Chapter Five details the research process, describing the methodology. The research comprises 20 parents taking part in individual semi-structured interviews. A description of the selection and recruitment of the participants - along with a description of the data collection process - is provided in the first part of the chapter. The remainder of the chapter focuses on a detailed description of the ethical issues considered and the process of analysis.

The following three chapters focus on parental constructions surrounding child medical care use and how the utilisation of child medical care is constructed by parents. In Chapter Six, parental talk surrounding child medical care use is explored for predominant constructions that are drawn on in parents' accounts. The findings presented in this chapter reveal that these parents actively construct children, the parenting role and the 'good parent', the medical profession and their relationships with health professionals, childhood illness and disease, and medicines, in various and complex ways. This chapter reveals the complex and contradictory nature of these constructions and how they are often used in multiple ways to legitimate and defend parents' actions regarding child medical care use.

The following two chapters explore how parents construct their child medical care use. Chapter Seven explores parents' talk regarding deciding whether or

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not to take an ill child to the doctor. Chapter Eight explores parents' talk about deciding whether or not to utilise Well Child checks and childhood immunisation. The analysis presented in these chapters highlights how such child medical care use is conceptualised as a complex socially based decision-making process comprising the negotiation of various issues and concerns that arise and are resolved within a particular social context. This is a social context within which child health, illness, and disease are medicalised and within which parents are trying to do the right thing for their children.

In Chapter Nine the thesis is concluded with a general discussion of the main observations. The contribution this research has made to knowledge and understanding in the area of child medical care use is detailed, and it is suggested that this research has a number of implications for research and practice in the area of child health. This chapter ends with a look at the limitations of the research, and recommendations for future research are made.

## CHAPTER TWO

### EXAMINING CHILD HEALTH IN NEW ZEALAND

The health needs of children require special consideration with regard to the structure, organisation, and delivery of medical care and the development of effective interventions and initiatives aimed at improving child health. Such special consideration is important because these needs differ remarkably from those of adults and can arguably have a greater impact. More specifically, the health needs of children are of particular significance because of the developmental vulnerability of children, the particular risk factors they face, their susceptibility to health risks, and the impact of illness and disease not only on children but also on society in general.

To begin with, childhood is characterised by substantial and rapid physical, cognitive, and social developmental changes, including - for example - the mastering of language and social skills. In fact, the greatest progress in these areas takes place during childhood (Ochiltree, 1991). Illness during childhood can disrupt the important developmental and growth processes of that period

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having physical, social, and cognitive implications for the child, in both current and later life. For example, one possible consequence of glue ear is hearing loss which can significantly affect a child's speech, emotional, social, and cognitive development (Department of Health [DOH], 1990; Public Health Commission [PHC], 1995). Illness may also disrupt the important processes of cognitive and social growth by causing children to fall behind in education due to missed learning opportunities (Atwool, 1996; Nelms & Mullins, 1982).

Poor child health and development also has wider implications for New Zealand society in general. That is, they ultimately have an adverse effect in broader social outcomes such as violence, crime, and unemployment (MOH, 1998b).

Illness during childhood not only has the potential to compromise growth and development, it can also impact upon future physical health. The risk factors for many adult diseases arise during childhood, as do the opportunities to prevent them (Ministry of Health [MOH], 1998b). For example, increasing evidence suggests that adult diseases such as rheumatic heart disease, chronic liver disease, and liver cancer are associated with childhood illnesses and diseases such as rheumatic fever and Hepatitis B (MOH, 1999a). The long-term costs of childhood illness can include chronic illness, disability, and premature death (MOH, 1998a; 1999a).

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Additionally, children are particularly vulnerable to a number of health risks. For instance, children are particularly susceptible to some potentially particularly harmful illnesses such as respiratory conditions and infectious diseases (MOH, 1999a). New Zealand research has also revealed that the prevalence of illness is higher among young children than any other age group (Parr, Whittaker, & Jackson, 1998).

Altogether, the costs of childhood illness demonstrate that it is during the first few years of a child's life that primary and preventive medical care, such as immunisation, can play an important role and can have the most impact on a child's present and future health and development (MOH, 1997b). This highlights the importance of the provision and utilisation of these medical care services. I acknowledge that caring for child health and illness includes a range of general wellness activities, for example, surrounding diet and child safety, but (for reasons outlined in this chapter) I have chosen to focus upon the seeking of treatment and protection for childhood illness and disease from a medical practitioner or nurse, including the use of Well Child checks and childhood immunisation. Throughout this document I have adopted the term "medical care" to refer to care received by a medical practitioner or nurse so as not to confuse the reader with the broader term "health care" which is more often used to refer to general wellness activities.

The current state of child health in New Zealand is regarded as a major concern by both many health professionals and the Ministry of Health (MOH, 1998b).

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This concern is centred around the high rates of infant and child mortality, and of communicable disease, as well as the frequency of disease epidemics, and low rates of medical care utilisation.

Although New Zealand's high rate of mortality among infants (aged 12 months and under) has decreased over the last 40 years, it is still considered high in comparison to international standards (Statistics New Zealand [SNZ], 1998). In 1997, New Zealand's infant mortality rate was ranked 17th out of 19 OECD (Organisation for Economic Cooperation and Development) countries (SNZ, 1998). The latest available data reveal that mortality rates for children under 5 years are also declining, but New Zealand was ranked 15th out of 21 OECD countries for the year 1995 (MOH, 1999a).

Child mortality rates also suggest that child health in New Zealand is failing to improve as rapidly as rates in other OECD countries (MOH, 1998b). For example, New Zealand's international ranking for child mortality rates has worsened over the last 25 years, in comparison to other countries (MOH, 1999a). Of 21 OECD countries New Zealand experienced the fifth lowest rate of change in child mortality for children under 5 years. Further, research indicates that child health in New Zealand is declining, to some degree. The proportion of children under 15 years hospitalised has substantially increased over the last 20 years; in 1974, the rate of child hospitalisation was 89.6 per 1,000 which increased to 197.5 in 1995 (SNZ, 1998).

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A major cause of child hospitalisation and a significant contributor to child mortality in New Zealand is communicable disease (MOH, 1998a; 1999a). Acute respiratory infections (ARI) including croup, bronchitis, bronchiolitis, and pneumonia were among the primary causes of child hospitalisation in 1995 (MOH, 1998a). The principal causes of infant mortality in 1996 included pneumonia and influenza (New Zealand Health Information Service, 1999). Pneumonia, influenza, bacterial meningitis, meningococcal infection, and congenital pneumonia were the leading causes of child communicable disease deaths in 1994 (MOH, 1998c). Meningococcal disease also increases child morbidity, with incidence rates increasing, leading to a hyperendemic situation that is expected to continue (ESR, 1997; MOH, 1999a). In comparison with countries such as Australia, Japan, United States, Canada, and the United Kingdom, New Zealand's rate of child mortality due to communicable disease is considered to be high (MOH, 1999a).

Although the incidence of many communicable diseases is declining, particularly since the introduction of immunisations, few have been totally eradicated (MOH, 1999a). In fact, disease epidemics of vaccine-preventable diseases are still prevalent (MOH, 1998c). Epidemics pose a major threat as the extent of their effects is serious and widespread. For example, during a 3-year pertussis epidemic that began in 1995, close to 800 children were hospitalised (Blakely, Baker, & Galloway, 1997, cited in MOH, 1998c). During a measles epidemic in 1997, approximately 300 children were hospitalised (Mansoor, Blakely, Baker, Tobias, & Bloomfield, 1998).

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An area of particular concern for child health in New Zealand is the utilisation of medical care services. Many health care professionals and the Ministry of Health consider current child medical care utilisation rates to be inadequate to achieve optimal child health (MOH, 1998a). As a result, this concern has received a substantial amount of attention and is the subject of numerous public health campaigns and initiatives that are aimed at promoting, improving, and protecting child health. These initiatives include free childhood immunisation, free doctors' visits and prescriptions for children under 6, and free "Well Child" checks - which include developmental checks, and vision and hearing screening - for children under 5 years (MOH, 1998b; Ministry of Youth Affairs, 1995). Child medical care services, such as Well Child checks carried out by Plunket nurses and childhood immunisation are considered important for ensuring good child health and development within New Zealand (MOH, 1997b; SNZ, 1998). The failure or delay in using these services is a cause for concern because it is believed that the prevention, and early detection and treatment of certain childhood illnesses and diseases - such as measles and chronic ear infection - can assist in avoiding potential harm and disability in children. In particular, many of the illnesses and diseases that significantly contribute to infant and child hospitalisation and mortality rates are considered to be potentially preventable or treatable with the use of child medical services before they reach this stage. Further, it is believed that by maximising the number of children utilising these services these health concerns can be reduced (Central Regional Health Authority, 1997; MOH, 1998a; Tupasi et al., 1989).

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It should be noted that it is acknowledged by the Ministry of Health and health professionals that there is more to child health than medical care services and their appropriate use. That is, child health is seen as being influenced by a complex range of interrelated factors, such as income, poverty, and housing (MOH, 1998b). Thus, medical care services and their use are not considered the only factors involved in ensuring good child health and development but they have been identified as priority areas for improvement (MOH, 1998a, 1998b, 1998c).

A particular focus for concern regarding the use of child medical care is childhood immunisation, as inadequate coverage levels constitute a major public health issue. Although immunisation coverage levels increased between 1992 and 1996, in 1996 it was estimated that only 63.1% of children in the Northern region were fully immunised by 2 years of age (McNicholas & Baker, 1996; Rainger et al., 1998). Further, coverage levels tend to decline as children get older, as immunisations are not completed (Essex, Smale, & Geddis, 1995; King, White, & Thomson, 1993; McNicholas & Baker, 1996; New Zealand Communicable Disease Centre [NZCDC], 1992; Rainger et al., 1998). This decline in coverage levels is heightened by the decrease in immunisations given on time. Delay patterns of childhood immunisation tend to increase for the later immunisations (King et al., 1993; NZCDC, 1992). Overall, immunisation uptake rates are regarded as inadequate to prevent disease epidemics in New Zealand (McNicholas & Baker, 1996).

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Existing research into the utilization of child medical care suggests that this is a complex issue. Overseas research (e.g., Campion & Gabriel, 1984; Cunningham-Burley & Irvine, 1987) has shown that the majority of childhood illnesses are dealt with by the parent or caregiver and that only a small amount actually reach the attention of health professionals. Additionally, research conducted within New Zealand demonstrates that despite public health initiatives such as introducing free health care for children under 6 years, that have significantly increased the accessibility and availability of child medical care services, parents may still choose to delay - or choose not to use - these services (e.g., MOH, 1999b; NZCDC, 1992). There may be instances when parents do not consider it necessary or appropriate to seek medical assistance. Conventional medical interventions, such as immunisations, may be viewed as unnecessary and potentially harmful for children and their health. Additionally, parents may choose to use alternative health systems to deal with childhood illness and disease. Further, research and literature in the area of child medical care use demonstrates that among New Zealand parents there is some resistance and opposition to the views and values of medical science on issues surrounding child health care, such as childhood immunisation (e.g., Dew, 1995; Mansoor, Sarfati, & Durham, 1998; White & Thomson, 1995). Groups have also been formed in New Zealand that challenge the views and values of medical science. These groups include the Immunisation Awareness Society and Justice Awareness and Basic Support (JABS) which both promote an informed decision regarding childhood immunisation. Overall, such research and literature not only suggests that providing child medical services,

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and promoting and facilitating their use does not necessarily mean that they will be accepted or used, it also undermines the assumption that the utilisation of such medical care involves merely a simple relationship between prompting or symptom recognition and medical care utilisation.

Although previous research within New Zealand has provided some insights, there is currently little research that provides an in-depth understanding of parental decision-making regarding the utilisation of child medical care for the prevention and treatment of childhood illness and disease. Further, the unique context surrounding child medical care use within New Zealand, for example, New Zealand's policy regarding free visits to a doctor for children under 6 years, suggests that simply extrapolating findings or understandings reached from overseas research will not necessarily provide an adequate solution.

Within the context of child health care the role of parents is central. Children are not in control but are instead dependent upon their parents to care for them appropriately and effectively. Looking after the health of children involves making numerous judgements and decisions on the part of parents. When a child becomes ill parents have to make sense of bodily or other changes and decide on a path of action, for example, whether to seek help or to care for the child at home. Because parents are the primary agents in caring for children, their decision-making surrounding child medical care use is particularly important with regard to child health. Because research and literature indicate that the utilisation of child medical services is a complex issue, with parents

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often choosing not to use available services, this suggests the need to obtain additional understanding of parental decision-making surrounding child medical care use. Moreover, this demands greater in-depth research into child medical care use if the status of child health within New Zealand is to be improved.

Exploring parental decision-making involved in the utilisation of child medical care can provide a basis for the planning and development of effective interventions and initiatives. This is not necessarily with the aim of improving child medical care use but for aiding parental decision-making and appropriate utilisation of medical services, with the ultimate goal of ensuring safe and effective health care and illness management, and thus optimal child health.

In conclusion, children have unique health care needs, and receiving adequate and appropriate medical care can have a great impact on current and future child health and development. Within New Zealand there are a number of issues that are a cause for concern regarding child health. These include infant and child mortality and morbidity, communicable diseases, disease epidemics, and child health care use. Improving the utilisation of child medical care has been a particular focus for government initiatives as it is believed that doing so will help to enhance the status of child health in New Zealand. Parental decision-making surrounding the use of child medical care is a complex issue which has remained relatively untapped within New Zealand in terms of research. One way of enhancing child health is to obtain an in-depth

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understanding of the complex decisions parents face surrounding child medical care utilisation. In doing this, efforts can then be focused on aiding parental decision-making, in those areas where it is needed, to improve the status of child health within New Zealand.

### **CHAPTER THREE**

#### **RESEARCHING CHILD MEDICAL CARE USE**

Currently, there is little research in New Zealand that provides an in-depth understanding of parental decision-making surrounding the utilisation of child medical care, but a substantial amount has been conducted overseas. In general, this research has adopted a variety of perspectives, approaches, and methods in an attempt to explain, predict, and change parental utilisation of child medical care. Although this research has made a significant contribution to understanding child medical care use, much of it is characterised by a number of limitations that indicate the need for a different approach to such an investigation. The limitations evident within this research consist of failing to consider lay understandings, the diversity of processes involved, and the context of child medical care use, along with failing to consider child medical care use as a complex dynamic process, and approaching investigations in a restrictive manner.

## CONSIDERING LAY UNDERSTANDINGS

There is a growing body of research revealing that lay people hold quite complex and sophisticated understandings surrounding health and illness. These include understandings of health and illness, the role of medicine therein, theories of illness causation and treatment, and health maintenance (Calnan, 1987; Morgan, Calnan, & Manning, 1985; Nettleton, 1995; Radley, 1994; Research Unit in Health and Behavioural Change, 1989; Williams & Calnan, 1996b). Research into such understandings demonstrates the importance that identifying and exploring these can have for understanding child medical care use.

Much research into child medical care use has focused on the identification of particular variables that impede it, predominantly doing so from a biomedical perspective. Within the biomedical perspective biomedicine is accredited with superior knowledge or the status of 'truth' or 'fact', in contrast with the status of 'belief' accorded to the knowledge of everyday (non-experts) people. Additionally, medical care is considered a necessity, the most rational and accepted courses of action are biomedically defined with the medical establishment determining what is appropriate or inappropriate. There is an assumption that illness is dysfunctional and that the formal medical system provides a necessary solution to this dysfunction. Further, the relevancy of research problems is defined by the medical establishment.

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This biomedical focus brings with it a neglect of the lay perspective. In doing so, this research often portrays lay people as uncritical and passive recipients of the biomedical perspective. Contrary to this simplistic portrayal, it is argued that people are not simply passive recipients of biomedical beliefs, but that they are conscious reflexive actors who actively construct their own meanings and understandings of health and illness and how they should be managed (e.g., Stainton Rogers, 1991). That is, “people are more than just passive recipients of handed-down knowledge; they are also themselves continually engaged in its construction” (Stainton Rogers, 1991, p. 31). Further, it is argued that people are not necessarily persuaded by biomedical ideology and technology (Williams & Calnan, 1996b). Rather, lay people are seen as becoming increasingly critical and sceptical of the biomedical paradigm and values (Williams & Calnan, 1996b), and strong forms of resistance are beginning to emerge. This does not mean that there is a wholesale rejection of biomedicine altogether, but more and more people are turning to alternative medicine, and often as a result of unhappiness with orthodox medicine (Nettleton, 1995; Stainton Rogers, 1991; Williams & Calnan, 1996a).

Following from this, it cannot be assumed that parental understandings are the same as professional medical knowledge. Because biomedicine is predominant in Western nations it is bound to influence lay understandings, but it is only one information source amongst many (Blaxter, 1983; Calnan, 1987; Pill, 1997). Parents may also draw on information from friends and family, their own experiences, the media, including television documentaries and films, books,

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and alternative health systems (Blaxter, 1983; Lupton, 1994; Radley, 1994; Rogers, Hassell, & Nicholaas, 1999). It is important to point out that the distinction between lay understandings and biomedical knowledge should not be overemphasised, as lay understandings are not totally separate from biomedical knowledge (Rogers et al., 1999). Ideas may be borrowed from biomedicine and reinterpreted and integrated into lay knowledge, and continuously developed and shaped by people's experiences and social interactions (Freund, 1991; Nettleton, 1995; Pill, 1991). Overlaps in, and the shared use of, terms and values between lay people and health professionals have been highlighted in recent research (Rogers & Elliot, 1997).

Further, knowledge of lay understandings is important for understanding decision-making surrounding child medical care use. That is, behaviour that is regarded as appropriate according to biomedicine may be valid when considering the lay understandings surrounding this behaviour (Research Unit in Health and Behavioural Change, 1989). For example, Graham (1987) has suggested that cigarette smoking among young mothers provides a way of structuring their days and giving themselves "space" for self-directed activity that does not impact upon child care activities. Further, when people are carrying out biomedically appropriate behaviour, this may be according to rationality that differs from that of biomedicine; a rationality that may have minimal pertinence to health (Research Unit in Health and Behavioural Change, 1989). That is, behaviour may be carried out for reasons other than a concern for health. For example, a parent may take a sick child to the doctor not just for

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medical treatment, but also for relief for the family from the pressures of dealing with a sick child. Because these lay understandings provide a context for understanding decision-making and practices surrounding issues of health and illness they have great implication for developing effective interventions.

Despite this research demonstrating the importance of exploring lay understandings, there is little child medical care use research that delves into, and explores, parental understandings surrounding issues of seeking and utilising child medical care. The arguments that parents actively construct their own meanings, that these differ from those of biomedicine and health professionals, and that they are invaluable for understanding decision-making suggest the need to move away from attempting to explain parents' decision-making and actions purely in terms of biomedical rationality or understandings. Rather, emphasis should be placed on moving towards attempting to understand parental decision-making and behaviour within parents' own knowledge framework, such as the understandings they have of child health and illness and actions surrounding these, and to do justice to the ability of parents to think critically, as opposed to being passive recipients of biomedical beliefs. This approach is of particular importance when considering that it is within the lay arena that issues of child health and illness are negotiated, decisions are made, and health care activities take place. Such a move calls for an approach that is flexible enough to suspend biomedical rationality and explore the knowledge frameworks within which parents care for childhood illness and protect and maintain child health.

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## ACCOMMODATING A DIVERSITY OF PROCESSES

A popular focus for research into child medical care use is the individual deliberative decision-making processes involved in using child medical care. For example, Kviz, Dawkins, and Ervin (1985) investigated, using the Health Belief Model, mothers' cost-benefit analyses of using well-baby services. Also, Pacis (1990) investigated the relationship between mothers' cost benefit analysis, once again within the Health Belief Model framework, and health locus of control concepts in regard to use of childhood immunisation. Essentially, these frameworks assume that mothers weigh up the expected benefits of an action against the costs and adopt the action considered if the balance is favourable. Research into child medical care use that has been conducted adopting such a framework differs not only in the range of costs and benefits considered, but also in the specific equation used to predict the likelihood of action being taken.

Within this research, parents are conceived of as essentially rational decision-makers who consciously and systematically deliberate and evaluate available information before forming a behavioural intention or action. Ultimately, parents are attributed with unrealistic capabilities regarding cognitive processing. It may be that parents do not always engage in deliberative processing to the extent proposed, or that on occasions they may avoid deliberative processing altogether. There is no disputing that people deliberate, but it is highly unlikely that the costs and benefits of every behaviour are

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extensively examined to the same degree before action is taken (Fife-Schaw, 1997). Fazio (1990, p. 78) has argued that to do so would be “enormously dysfunctional for daily living”. By focusing on the conscious processing of information, such research disregards the possibility or plausibility of spontaneous or automatic processing guiding behaviour as well as ignoring the social context in which they operate.

To account for this, Fazio (1990) developed a model of the attitude-behaviour relationship that outlines how behaviour need not always involve systematic deliberation, but may at times be guided by automatic or spontaneous processing. It also elucidates how both spontaneous and deliberative processing can be conceptually integrated into such a model. In particular, this model states that social cognitive factors, such as attitudes, may influence behaviour with, or without, conscious or systematic deliberation. The mode of processing adopted is determined by whether or not the person has the opportunity and/or motivation to engage in such processing of information. For example, in an emergency situation, there may be insufficient time available for parents to examine the likely outcomes of their behaviour or to weigh up the costs and benefits involved in taking the child to the hospital. Conversely, with regard to deciding whether to have a child immunised, because this behaviour may be considered highly consequential, the parent may be more motivated to make a carefully reasoned analysis.

A number of researchers have suggested and researched similar distinctions between deliberative and automatic processing of information (e.g. Bargh, 1990; Chaiken, Lieberman, & Eagly, 1989). For example, Ronis, Yates, and Kirscht (1989) claim that when a behaviour has become habitual no conscious thought is involved: it is automatic behaviour. Similarly, Weinstein (1988) claims that behaviour may be directly influenced by the opinions and behaviours of others, thus bypassing a cost-benefit analysis. For example, when considering whether or not to immunise a child, parents may go by the advice of their general practitioner as opposed to making the decision themselves. According to Weinstein (1988) the avoidance of the whole decision process is most likely to occur when: "(a) issues are complex, (b) the requisite information is difficult to obtain, (c) the choices of others are apparent, (d) experience with a hazard is limited, and (e) the cost of the action is relatively small" (p. 373).

Although there is evidence supporting these theories (e.g., Fazio, 1990), they have been subjected to a number of criticisms that indicate the need for further work and development (e.g., Stroebe & Stroebe, 1995). Despite the need for further research, these theories provide an introduction into the diversity of processes that may be involved in decision-making surrounding the utilisation of child medical care. Much of the research into child medical care use focuses solely on the deliberative decision-making processes involved, and as a result the importance of non-deliberative decisions is down-played. This suggests the need to adopt an approach to child medical care utilisation research that is

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sensitive to - and can accommodate - the diversity of processes involved in decision-making surrounding the utilisation of child medical care.

### THE IMPORTANCE OF CONTEXT

Focusing solely on the individual cognitive processes involved in child medical care use presents a further problem. Such an approach conceptualises parents as free to make choices, and diverts attention away from the broader context within which decisions and actions take place; producing a decontextualised account of child medical care use. A result of this approach is that the role of outside constraints or pressures, such as cost and social networks, in child medical care use are minimised, and the control and responsibility that parents have over child health is overstated. This individualistic focus has certain implications for improving the utilisation of child medical care. In particular, changing parental cognitions may be seen as the key or focus for improving child health. This may result in public health efforts being directed more at changing individual cognitions or behaviour, in an attempt to enhance child health, with less effort being given to issues such as cost and social networks. I am not claiming that parents do not have any responsibility or control regarding child medical care use, but merely that it is important not to overstate the importance of the role of individual decision-making processes and to acknowledge that they are merely one aspect of child medical care use that is important in ensuring good child health.

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A particular cost of adopting an individualistic focus is the neglect of the social context of child medical care use. Medical care use is not just an individual matter. Social interaction and social networks are essential elements in the utilisation of child medical care. Spouses or family members may be important decision-makers with regard to child medical care use and a decision may need to be agreed upon among them. Further, parents often resort to their social networks, which may include family, friends, neighbours, and fellow employees, as resources for knowledge, advice, and support. This is often referred to in the literature as the lay referral system.

The role that social networks and social interactions play is twofold. Firstly, they may influence the decisions and actions of parents. Research has shown that social networks play an important role in influencing health and illness behaviour, such as health service utilisation (Rogers et al., 1999). The extent of the impact of social networks on health and illness behaviour is inconclusive (Rogers et al., 1999).

Secondly, social networks and social interactions may also be considered as mechanisms underlying or through which these decisions and actions are made. To elaborate, social interactions and social networks are important in the dynamics of the decision-making processes involved in child medical care use. According to Pescosolido “a particular action, choice, or decision is embedded in a social process where the network interactions of the individuals not only influence preference formation and define the situation but also drive the

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process of deciding whether something is wrong, whether anything can be done about it, what should be done, and how to evaluate the results" (1992, p. 1104). Despite the value of this research, I am not arguing here that Pescosolido's particular approach to dealing with the social context of medical care use should be adopted for researching the utilisation of child medical service use. What I am suggesting is that such research into the social context of medical care use demonstrates the importance of investigating this aspect of child medical care use.

Exploration of the context of the decision-making and actions taken surrounding child medical care use is integral to understanding this area. Parents' decisions and actions regarding the use of child medical care are infused within the specific and wider situation in which they take place, and cannot be simply separated from this context. Ultimately, it is within this wider and immediate context that child medical care use is negotiated and undertaken. Setting it within this context enables it to be viewed in a more informative light.

On the other hand, focusing exclusively on outside or structural factors and not paying enough attention to the role of the parent also presents problems. Doing so may lead to parents being portrayed as mindless as opposed to being active persons making decisions to seek and utilise child medical care. Such an approach can lead to the neglect or undermining of the significant role of parents.

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The importance of the wider context of child medical care use is often downplayed or ignored in child medical care utilisation research. While empirical studies clearly show how particular circumstances, such as parents' socio-economic situation, influence child medical care use (Health and Disability Analysis Unit, 1997; MOH, 1999b), although such information sets decision-making and actions surrounding child medical care use within the actual circumstances and constraints of everyday life, little attention is given to the wider context of child medical care use. Within research into child medical care use this complex phenomenon is often reduced to isolated factors and the decisions and actions involved are often treated as discrete events. Further, research tends to focus on the individual cognitive processes involved. Altogether, doing so removes child medical care use from the context in which it is negotiated and undertaken.

To summarise, context plays an important role in child medical care use. It has been argued that the utilisation of child medical care can really be fully understood only in the context in which it takes place and so should not be addressed in isolation from this. It has also been argued that investigators need to be careful not to focus exclusively on outside factors. This means that researchers need to find a balance between focusing on contextual factors and individual factors. Thus, it is the parent/s interaction with the overall context that should be considered in child medical care use research. This suggests the need for an approach to researching child medical care use that can capture and explore this interaction.

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### ACCOMMODATING PROCESS

A further difficulty in treating the decisions and actions involved in child medical care use as discrete events is that the idea of these occurring as part of a pathway or process is ignored or down-played (Nichter, 1995). Much of child medical care use research is directed at finding out what factors are either associated with - or influence - child medical care decisions and actions, and how they may interact. Such factors have included health beliefs and attitudes (Bennett & Smith, 1992; Cornford, Morgan, & Ridsdale, 1993; Fosu, 1991; Kviz et al., 1985; Tinsley & Holtgrave, 1989), socio-demographic characteristics (Bates, Fitzgerald, Dittus, & Wolinsky, 1994; Essex et al., 1995; Li & Taylor, 1993; Pearson et al., 1993; Zeitlyn et al., 1992), psychosocial factors (Riley et al., 1993; Watson & Kemper, 1995), psychological factors such as parental anxiety (Goldman & Owen, 1994; Hatcher, Powers, & Richtsmeier, 1993), and religiosity (DeVellis, DeVellis, & Spilsbury, 1988). In order to investigate these factors a snapshot of the decisions and actions involved in child medical care is taken at one or several points in time. Thus, interest is directed at the event or outcome and not the process involved in getting there. This means that we do not find out how parents come to act. To focus on the point of choice or outcome of health and illness behaviours means that a moment is isolated in what is often an ongoing story of decisions, confronted issues, and numerous attempts to deal with matters of health or illness (Sharma, 1996). Overall, the focus is on a relatively static perspective of child medical care use.

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Rarely does health and illness behaviour or decision-making occur in isolation; rather, research in other areas of health behaviour has described such phenomena as a complex process. It has been postulated that people pass through several different stages or phases over time in the contemplation, initiation, and maintenance of health and illness behaviour (Norman & Conner, 1996). In particular, a number of stage models have recently been developed and are increasingly being applied to a range of health behaviours including the adoption of preventive behaviours and health care utilisation. Such models include the transtheoretical model (Prochaska & DiClemente, 1984), the health action process (Schwarzer, 1992), and the precaution adoption process (Weinstein, 1988; Weinstein, Lyon, Sandman, & Cuite, 1998; Weinstein & Sandman, 1992). Other stage theories emphasise particular behaviours such as delay in seeking health care (Andersen, Cacioppo, & Roberts, 1995).

Although the concept of a staged process is a popular one, there is evidence to suggest that people do not necessarily pass through distinct stages in health and illness behaviour (Abraham & Sheeran, 1997; Sutton, 1996). As a result, it has been suggested that there is a need for more research to further determine the existence of stages of health and illness behaviour and decision-making (Weinstein, Rothman, & Sutton, 1998). The need for such research is driven by the fact that the conceptualisation of medical care use as a process, whether it be defined by distinct stages or not, is valuable in a number of ways. These arguments are of particular relevance to furthering understanding of child medical care use.

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To begin with, child medical care use is characterised by motion and change. For example, an episode of childhood illness does not involve a single, yes-no decision as to whether to seek professional medical care; rather, it involves patterns of practices, decisions, and dilemmas. Parents may go down various pathways involving a number of decisions and actions that often build on each other during the course of time. This means that summarising child medical care use by a one-time decision rule is rather simplistic. Not only must we consider why parents act in the way they do, we need to consider also how parents come to act. A process conceptualisation elucidates and allows for the examination of such motion and change over time (Leventhal, Diefenback, & Leventhal, 1992) and in doing so provides a powerful framework for the development of more detailed theories of child medical care use. Further, resources can be focused on those issues that can aid movement through the process in a manner that fosters child health.

Secondly, a distinctive feature of staged process models is that different factors are found to be important at different stages (Norman & Conner, 1996; Weinstein, 1993; Weinstein, Lyon et al., 1998; Weinstein, Rothman et al., 1998). This means, for example, that those factors that are important in recognising illness may not be the same as those that are important in deciding what action to take to deal with the illness. Thus, a process conceptualisation enables the identification of points or stages of child medical care use where certain factors or issues are particularly influential or apparent. In this sense, the

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conceptualisation of child medical care use as a process can be potentially useful for understanding and enhancing child medical care use.

Thirdly, a process conceptualisation provides an effective guide for the development of tailored and, as a result, arguably more effective interventions (Weinstein, Lyon et al., 1998). By conceptualising child medical care use as a process, interventions can be more specifically designed to apply to particular parts of the process. This means that adopting such an approach to researching child medical care use not only has the potential to provide new and important information to further understanding in this area, it could also further the development of interventions aimed at improving child health.

In summary, general research on health and illness behaviour is beginning to conceptualise such behaviour as a complex dynamic process and to illustrate the potential for doing so. Despite this, research into child medical care use still tends to adopt a static perspective, looking at the choice and not the episode, thus failing to capture this important feature of child medical care use. Instead of assuming that processes are occurring it is time to look at them as subject matter in their own right. As argued above, it is time we moved beyond a static perspective of child medical care use and adopted an approach that enables us to capture the entire process involved, not just the variables or a stage in isolation, and to conceptualise child medical care use as the complex dynamic process that it is.

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**THE NEED FOR AN OPEN AND FLEXIBLE APPROACH**

To research a complex phenomenon such as child medical care use an approach is needed that is open and flexible, in that it enables the researcher to enter into and explore the world of the participant in an unrestricted manner. The value of such an approach is that it not only allows for discoveries to be made, but it also allows for the emergence of factors, constructs, models, or theories that capture the world of the participants.

Most approaches taken to researching child medical care use, to a certain extent, do not allow for an element of openness and flexibility. Much of this research is driven predominantly from pre-existing constructs, models, and theories, such as the health locus of control and the Health Belief Model (e.g., Pacis, 1990; Weitkunat et al., 1998). At a methodological level, the investigation of pre-existing constructs and theoretical formulations often brings with it the adoption of a deductive approach to research design. This approach involves formulating hypotheses from existing theories prior to the research and data analysis with the aim of supporting or refuting these hypotheses (Charmaz, 1995). Further, such research also brings with it the use of developed measures, such as Health Locus of Control Scales and Parental Health Belief Scales (Pacis, 1990; Tinsley & Holtgrave, 1989). Within the interests of control, these measures restrict participant responses to fit into predetermined categories that have been set by the researcher or the person who originally developed the measure.

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Approaching the data within the confines of testing predefined hypotheses and predetermining and restricting participant responses works to impose the researchers' views or the framework they have chosen of how the world works onto the social worlds of the participants (Stainton Rogers, 1991). Harré (1979, p. 115) argued that "the use of questionnaires with limited range questions...which effectively preclude elaborations and reinterpretations...means that the concepts deployed...are predetermined. The effect of this is to produce not a representation of the social world being studied, but the representation of the shadow cast upon the social world by the prior conceptual apparatus deployed by the person who constructed the questionnaire". For example, when Tinsley and Holtgrave (1989) and Weitkunat et al. (1998) applied the health locus of control, and the appropriate measures, to their research into child medical care service use, they imposed this attributional framework onto the data and the parents' viewpoints, and made no room for other viewpoints to be expressed or any attempt to understand the issue from the participants' world view.

Additionally, the adoption of pre-existing constructs or theories, testing predefined hypotheses, and using restrictive measures impose a certain restriction on researching child medical care use that inhibits the discovery or emergence of issues or processes beyond these that may also be of importance to understanding child medical care use. This means that such research works to either confirm or disprove existing pre-conceptions and rarely goes beyond these (Stainton Rogers, 1991). In particular, a biomedically defined problem or

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a biomedical framework is often imposed upon the participants, thus assuming it is relevant, and little consideration is given to letting the research agenda be set from the worlds of the participants.

Finally, the use of developed measures not only prevents the researcher from exploring participant responses, but it also precludes variability and response elaboration, and thus the provision of contextual information by the participant. In particular, flexible opinions and inconsistent responses are not allowed for in the response format of these measures (Potter & Wetherall, 1987); people are unable to respond “well, it depends” or “I’m in two minds - I both agree and disagree” (Stainton Rogers, 1991). In fact, as Stainton Rogers claims, “response variability is generally treated as something that needs to be ironed out of the study by using more people, more trials or more careful instructions; or as an indicator that the scale is faulty. It is seldom regarded as an expression of true inconsistency, itself worthy of study” (p. 120).

Further to this argument, adopting pre-existing theories, that are primarily generic, to research child medical care use can be questioned on the grounds that such general theoretical formulations are not necessarily suitable for conceptualising child medical care use. In particular, parents and caregivers of children are in a particular situation in which they are the primary agents in protecting, caring for, and maintaining a child’s health; not just their own. In fact, research has revealed a difference between factors that lead adults to seek care and those that lead mothers to seek medical treatment for an ill child.

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Turk, Litt, Salovey, and Walker (1985) suggest that mothers may go through a somewhat different decision-making process when seeking treatment for their children, rather than for themselves. Although further research is needed in this area, from this it may be argued that the application of generic theoretical formulations to child medical care use has been only relatively successful because they do not necessarily provide the most suitable framework for conceptualising child medical care use. Researchers need to be careful about adopting general theoretical formulations that do not allow for the uniqueness of this particular context to be captured and expressed as this may result in the omission of important features specific to child medical care use.

Altogether, researching child medical care use within the confines of pre-existing constructs or theories, testing predefined hypotheses, and using developed measures hinder the potential for discovery and the groundedness of the findings within the worlds of the participants. The continued researching of child medical care use within the confines of existing theory or constructs constrains the knowledge and understanding that can be obtained regarding child medical care use. This argues the need for the adoption of an approach and set of methods that can provide an open and flexible investigation of child medical care use that not only allows the research agenda to focus on what is important in the worlds of the participants but also better captures the complex phenomenon of child medical care use by parents.

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In conclusion, previous research into child medical care use has made some valuable contributions to understanding in this area, but the strength of these contributions is weakened by the limitations in the approaches taken. Although many of these issues are complex and difficult to resolve, I have argued that researchers can begin to address such limitations by adopting an approach that enables them to investigate parental understandings, be sensitive to and accommodate the diversity of processes involved, recognise and conceptualise child medical care use as the complex process that it is, contextualise child medical care use, and to foster discovery and capture the lived world of the participants. Adopting such an approach will ultimately lead to further understanding of child medical care use. The grounded theory approach provides the potential to do this.

## CHAPTER FOUR

### A GROUNDED THEORY APPROACH

The term grounded theory has come to mean two different things (Henwood & Pidgeon, 1994; Pidgeon, 1997). Firstly, grounded theory is often referred to as theory that is inductively derived from, or grounded closely in, the data. Secondly, grounded theory is also referred to as (and this is the use of the term I have adopted here) a methodology that provides a set of systematic strategies or techniques for building theory that is grounded in or inductively derived from the data. In accordance with this use of the term, the purpose of grounded theory methodology is to generate or build theory that is “faithful to and illuminates the area under study” (Strauss & Corbin, 1990, p. 24).

Grounded theory methodology has increasingly been applied in a range of disciplines including nursing, anthropology, and psychology (Henwood & Pidgeon, 1994; Rennie, Phillips, & Quartaro, 1988; Strauss & Corbin, 1994). Within the discipline of psychology, grounded theory has been diversely applied to topics in social psychology, clinical psychology, educational

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psychology, community psychology, and psychotherapy (e.g., Currie, 1988; Pilowsky, 1993; Polkinghorne, 1994; Rennie et al., 1988; Rottenberg & Searfoss, 1992). There has also been a rapid growth in the use of grounded theory by health scientists, particularly health psychologists (May, 1996). Using grounded theory, health researchers have investigated topics such as utilising health care during pregnancy (Patterson, Freese, & Goldenberg, 1990), conceptualisations of 'adjustment' to chronic illness (Wright & Kirby, 1999), and the emotional experience of breast expression (Morse & Bottorff, 1992).

The application of grounded theory methodology within a wide range of disciplines has resulted in diversity in how it is used. A growing number of researchers are adapting grounded theory methods, and combining them with other methods. For example, Gerson (1991) adapted grounded theory procedures to make theory construction more systematic and rigorous. Schatzman (1991; Kools, McCarthy, Durham, & Robrecht, 1996; Robrecht, 1995) developed dimensional analysis, which is considered another adaptation or variant of grounded theory (Chamberlain, 1999), to make theory development less prescriptive and to provide more developed techniques for theory generation. Wilson and Hutchinson (1991) combined Heideggerian hermeneutics with grounded theory, and Beck (1992, 1993) used grounded theory with phenomenology to investigate postpartum depression. Further, Wuest (1995) and Keddy, Sims, and Stern (1996) have also illustrated how grounded theory can be adapted to suit a feminist perspective.

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The diverse use of grounded theory methods has sparked considerable debate over what is the correct way to conduct grounded theory research, and what constitutes a proper grounded theory study. The most published debate is that between the founders of grounded theory, Barney Glaser and Anselm Strauss. With regards to such debates, one perspective is that for a study to take the grounded theory label it is essential that the grounded theory methods are followed prescriptively (Glaser, 1992; Smith & Biley, 1997). From this perspective there is concern that by modifying grounded theory methods, researchers are failing to understand important aspects of grounded theory, that the canons of grounded theory are being undermined and compromised, and that rigour of the research project cannot be maintained (Corbin & Strauss, 1990; Strauss & Corbin, 1994; Wilson & Hutchison, 1996). Overall, proponents of this perspective are concerned that grounded theory method is becoming “diluted and confused” (Smith & Biley, 1997, p. 29), and that the credibility and value of grounded theory is at risk (Wilson & Hutchison, 1996).

The perspective I have adopted is that grounded theory methods need not be adhered to rigidly or prescriptively, instead they should be adapted according to the circumstances of the project (Annells, 1997b; Chamberlain, 1999; Charmaz, 1995b; Pidgeon & Henwood, 1997a). The advantage of this is that researchers can selectively draw on and adapt grounded theory procedures in a way that is most suitable and valuable for the particular project being conducted (Chamberlain, 1999; Charmaz, 1995b). As Crotty (1998) argues, when conducting research a methodology needs to be forged that best meets

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the particular purposes of the research project whether this involves adopting an established methodology, drawing on and moulding several methodologies together, or creating a whole new methodology that suits the endeavour at hand, all the while being informed by various existing methodologies.

Correspondingly, rather than seeing grounded theory as eroding due to the modification of its methods, I view grounded theory as evolving as a result of such modification (Annells, 1997a; Benoliel, 1996; Keddy et al., 1996; Melia, 1996). Grounded theory procedures are developing and changing, being enhanced and refined, or as Annells (1997a, p. 129) puts it “maturing and branching”, necessarily in response to changing philosophical perspectives, and prevailing concerns and ideas surrounding the conduct of research (Annells, 1997b, Strauss & Corbin, 1994). Without such modification there is little chance that methods such as grounded theory can be improved upon or developed further.

Within this perspective, grounded theory methodology is perceived as providing a set of flexible procedures or strategies for conducting rigorous qualitative research; there is no one right or correct way to conduct grounded theory, but there are guidelines as to what can be considered to be a grounded theory (Chamberlain, 1999; Charmaz, 1995b). With this in mind, it should be noted that these selected or adapted procedures need to be made explicit to allow others to evaluate the research and to see how it differs from other grounded theory studies (Baker, Wuest, & Noerager, 1992; Corbin & Strauss,

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1990; Stern, 1994). I have talked here about variability in the use of grounded theory methodology, but variability is evident not only in this sense but also in the philosophical perspectives adopted by researchers using grounded theory methodology.

### **PHILOSOPHICAL ASSUMPTIONS**

Like all research, grounded theory is not just about adopting specific techniques for conducting research - it is also based on a set of philosophical assumptions about ontology and epistemology; what is and what it means to know. Researchers using grounded theory have done so from a number of different philosophical stances; from post-positivist to constructionist (Annells, 1996, 1997b; Charmaz, 1990; Constain Shou & Hewison, 1998; Pidgeon, 1997). For example, the two most discussed versions of grounded theory, the traditional grounded theory by Glaser (1978) and the reformulated grounded theory by Strauss and Corbin (1990), have been demonstrated to be leaning toward different epistemological and ontological assumptions. It is argued that Glaser is leaning towards neopositivism and Strauss and Corbin are claimed to be leaning towards constructivism (Annells, 1996, 1997a; Stern, 1994).

Within qualitative research a great deal of importance is placed on the need for researchers to clarify the philosophical assumptions that inform and guide their research (Annells, 1997b; Guba & Lincoln, 1994; Lowenberg, 1993). This is

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because implicitly or explicitly these assumptions have important implications for the research process, the interpretation of the findings, and the implications of the research (Chamberlain, 1999; Charmaz, 1995a; Guba & Lincoln, 1994). Thus, my intention here is not to provide a detailed review or discussion of the differing philosophical assumptions underlying grounded theory or circulating within research in general, as such discussions are abundant within the literature (e.g., Annells, 1996, 1997a, 1997b; Crotty, 1998; Fox & Prilleltensky, 1997; Guba & Lincoln, 1994; Nightingale & Cromby, 1999). Rather, my aim is to outline the philosophical stance within which the present study was conducted; a version of the social constructionist stance that unites a realist ontology with an epistemology of constructionism (Crotty, 1998).

The objectivist or realist position assumes that a meaningful reality exists and is waiting to be discovered by a detached neutral observer or inquirer. Things exist as meaningful entities independent of our consciousness or experience of them. This means that an observer or inquirer is detached from whatever is being observed, and therefore the observer or inquirer can observe something without influencing it. With regards to conducting research this means that an understanding of objective reality is aimed for by means of precise and controlled observation and measurement, and through experimental design that enables researchers to isolate confounding variables or factors from those variables of interest (Yardley, 1997a). If researcher influence is recognised it is reduced or eliminated using particular strategies (Guba & Lincoln, 1994).

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Contrary to the assumption that an objective meaningful reality exists “out there” to be captured, constructionism argues that a meaningful reality does not reside in objects or entities independent of our consciousness of them; a meaningful reality is not sitting waiting to be discovered. Rather, it is constructed in interaction with these objects or entities (Crotty, 1998). It can be argued that objects and such things as the biological body exist as concrete or material entities independent of our consciousness and experience of them, but these entities are given meaning when we engage with them and attempt to make sense of them (Crotty, 1998). People construct their own meaningful reality as they engage with and interpret the world (Crotty, 1998). This position does not mean that we all enter into the world and slowly make sense of phenomena as we come across them. Rather, we enter into a system of meaning bestowed upon us by our culture and time (Crotty, 1998). Meaningful realities are generated and transmitted within a social and historical context (Burr, 1995; Crotty, 1998; Yardley, 1997b). Knowledge is constructed through interactions between people in their daily lives; it is the result of the social processes people are engaged in (Burr, 1995; Crotty, 1998; Schwandt, 1994). So, knowledge is socially and historically specific; it is a product of a particular culture and time (Burr, 1995; Crotty, 1998; Stainton Rogers, 1996; Ussher, 1996; Yardley, 1997b). Ultimately, this assumption means that we cannot go out and find or obtain a meaningful reality. We cannot discover “how things really are” and “how things really work”. Accordingly, knowledge and truth are not considered reflections of a reality, meaningful or material, rather they are socially constructed.

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This assumption also brings with it the understanding that there can be no objective detachment between the knower or inquirer and what can be known (Crotty, 1998); there cannot be an objective observer. Thus, it is argued that the ideal of objectivity is illusory. To obtain an objective observation independent of the inquirer is impossible (Yardley, 1997b). It is impossible for inquirers or observers to be totally detached from what they are observing. Rather, with regards to conducting research, the researcher is actively involved with and interacts with the research process every step of the way. Further, the researcher is influenced by many factors such as goals, values, politics, or previous experience, which ultimately affect the research questions asked, the philosophical assumptions adopted, and interpretations of the data (Usher, 1996; Yardley, 1997b). As Yardley argues:

Rather than collecting neutral data, the investigator frames the question, picks the participants, and then interacts with them to produce the observations or texts used for analysis. Further processes of selection and interpretation shape the conclusions and presentation of the analysis: for example, the inclusion or omission of certain data; the examination of particular comparisons or associations; and the explanation of unexpected, ambiguous or inconsistent findings. Consequently, it is hypocritical to attempt to withdraw from the picture and treat the material or the findings of the research as an objective record of 'reality'. (p. 35-36)

Additionally, Burr (1995) argues:

Objectivity is an impossibility, since each of us, of necessity, must encounter the world from some perspective or other (from where we stand) and the questions we come to ask about that world, our theories and hypotheses, must also of necessity arise from the assumptions that are embedded in our perspective. No human being can step outside of her or his humanity and view the world from no position at all, which is what the idea of objectivity suggests, and this is just as true of scientists as of everyone else. (p. 160)

Thus, it can be argued that total objectivity cannot be obtained; an objective reality, meaningful or material, cannot be achieved and should not be the aim of research. But this position does not mean that scientific research should be discarded altogether, rather, it becomes important to recognise and acknowledge the role of the researcher in the research process and the results produced (Burr, 1995; Ussher, 1996; Yardley, 1997b).

By claiming that a meaningful reality does not reside in objects independent of our consciousness but is in fact constructed, an argument is presented - in terms of researching child health care use - for the need to adopt a philosophical stance that envelopes the constructed nature of "things" regarding child medical care, such as illness, and allows these to be explored. With regards to adopting such a stance there is the potential problem of slipping into an extreme relativist position and claiming that all knowledge is a social product

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(Burr, 1995; Bury, 1986; Lupton, 1994). Within such a position it is implied that there is no material base to our lives, rather things such as childhood illness exist only as constructions and thus can be understood only as constructions. As a result, the material or physical dimension of childhood illness, such as the biological body, is ignored or overlooked, and things such as the cost of medical care, that can have a tremendous impact on child health, are given a passive role as the objects of constructions and are regarded as solely constructions, thus the influence of these on child medical care use is denied (Nettleton, 1995; Ussher, 1996; Yardley, 1996, 1997b). This positions the physical or material dimension of childhood illness and medical care use as irrelevant and implicitly acknowledges that such physical dimensions are “beyond the scope of social science” (Ussher, 1996; Yardley, 1997b, p. 10). Overall, the physical or material reality of child health and illness is denied and conceptualised as a purely social construction. Further, the implications of such a position are not clear; how can it contribute to understanding child medical care use and what are the implications of this understanding? What does this understanding mean in terms of improving child health?

To slip into an extreme relativist position that ignores the material or physical aspects of childhood illness and child medical care use is problematic. However, the realist position is also problematic in that it ignores the importance of the constructed nature of things such as childhood illness. The world cannot simply be dichotomised into phenomena that are concretely real, such as the biological body, and phenomena that are socially constructed, such

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as illness (Yardley, 1997b). Rather, it is the material world that provides the basis from which we give meaning to things such as illness. As argued earlier, a meaningful reality is constructed in interaction with material objects or entities (Crotty, 1998). Thus, the material world plays a prominent role in the construction of meaning and vice versa (Burr, 1995; Crotty, 1998; Yardley, 1997b). Ultimately, there is a necessary interplay between the material world and the socially constructed world (Yardley, 1996). As Crotty (1998, p. 44) argued "...we do not create meaning. We construct meaning. We have something to work with. What we have to work with is the world and objects in the world."

This means that I have now arrived at a point where it is not appropriate to adopt a position that ignores the constructed aspects of child medical care use, but neither is it appropriate to adopt a position that ignores the material or physical reality of child medical care use. Current literature shows that there is a growing awareness of the need to consider how the constructed aspects of health and illness, for example, relate to their material aspects (e.g., Lupton, 1994; Radley, 1994; Ussher, 1996; Yardley, 1996, 1997b). A position needs to be reached where both the material and the constructed aspects of child medical care use can be acknowledged for their importance and it is recognised that meaning cannot be divorced from material reality. That is, a position needs to be adopted that recognises and embraces both the material reality of health medical care and how this reality is constructed. This position is a version of the social constructionist stance that unites a realist ontology with the

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epistemology of constructionism. It should be noted here that I am not claiming to have resolved these philosophical issues. Rather, these form part of continuous ongoing debates within, and beyond the boundaries of, social science research. Instead, my aim here is to provide an argument for the philosophical assumptions I have adopted for the present study.

With regards to the present study, adopting a version of the social constructionist stance that unites a realist ontology with an epistemology of constructionism enables me to talk about real life things and events, such as childhood illness and child medical care, while also recognising and acknowledging how these are socially constructed by parents. More specifically, this allows me to do several things. It allows me to delve into and explore parental constructions surrounding child medical care and how parents construct their medical care use. In doing so, I acknowledge lay or parental knowledge and meanings as legitimate and fruitful avenues of research and recognise parents as active constructors of meanings. This stance also enables me to recognise that social constructions can have physical implications and to pay attention to these implications. More broadly, this also allows me to consider the wider implications of these social constructions in terms of improving child health within New Zealand.

## GROUNDING THEORY FEATURES AND PROCEDURES

As a qualitative research approach, grounded theory methodology offers a number of features and strategies that are beneficial to psychological research, whether using a “strict” version of grounded theory, an adaptation, or whether conducting research that does not claim the grounded theory label at all (Chamberlain, 1999). In particular, consistent with the view that grounded theory methods can be selectively drawn on, there are a number of specific practices and techniques that grounded theory methodology offers that are of benefit and that have the potential to contribute substantially to the aims of the present study. I will now turn to discussing these features, issues surrounding them, and my positioning regarding these issues from the social constructionist position within which I stand. It should be noted that my aim here is not to provide a description of grounded theory, nor to provide a description of how to do grounded theory as there is a range of literature that details and discusses grounded theory extensively and how to conduct grounded theory from a number of perspectives (e.g., Bartlett & Payne, 1997; Chenitz & Swanson, 1986; Corbin & Strauss, 1990; Glaser, 1978; Glaser, 1992; Glaser & Strauss, 1967; Maykut & Morehouse, 1994; Pidgeon & Henwood, 1997a; Pidgeon & Henwood, 1997b; Rennie et al., 1988; Smith & Biley, 1997; Stern & Pyles, 1986; Strauss & Corbin, 1990).

Two primary tenets of grounded theory are the focus on theory development and process. With regard to the former, by focusing on theory development the

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researcher is required to move beyond a simple descriptive account of the phenomenon of interest, such as child health care use, to developing an abstract theory that conceptualises this phenomenon and accounts for relationships within it (Chamberlain, 1999). There are particular techniques and tools within grounded theory methodology, such as constant comparative analysis, that promote the development of theory that is “conceptually dense” (Strauss & Corbin, 1994). Using such grounded theory procedures, researchers can develop various levels of theory from substantive to higher level general or formal theory.

Although it is strongly argued that grounded theory studies should produce abstract theory (Glaser & Strauss, 1967), many grounded theory studies aim at producing rich conceptual analyses instead (Charmaz, 1995b). It is my belief, in accordance with Strauss and Corbin (1994), that both rich conceptual analyses and abstract theory are beneficial for different purposes, and it is in this sense that developing theory is no more important than developing rich conceptual analyses. So, consistent with the view that grounded theory methods can be selectively drawn on to enhance qualitative research, grounded theory methods can be adopted to develop either theory or conceptual analyses, depending on whether the researcher wants to pursue more basic questions or develop an abstract theory (Charmaz, 1995b).

In terms of investigating the utilisation of child medical care, moving beyond a descriptive account to developing an abstract theory holds promise for

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capturing the complexity of child medical care use and obtaining a full and deep understanding of this area that serves the need for improvement in child health and providing a framework for action. While description is useful, theory can be more powerful in terms of providing a basis for improving child health. Because grounded theory offers a systematic approach to - and powerful tools that facilitate - theory developing, it thus provides a valuable methodology for developing an understanding of child medical care use that best captures this complex phenomenon.

Further, grounded theory often involves the theorising of process. In particular, there is an interest in process both in the sense of “breaking phenomenon down into stages, phases, or steps” and in the sense of “purposeful action/interaction that is not necessarily progressive, but changes in response to prevailing conditions” (Corbin & Strauss, 1990, p. 10). Grounded theory researchers frequently seek a central process that underlies the particular phenomenon of interest and this is often referred to as the basic social process or the basic social psychological process. The analytic methods of grounded theory facilitate the investigation and exploration of such processes.

The value of investigating process is that it enables researchers to move beyond static analyses. In general, Charmaz (1995b, p. 30) argues that “by borrowing and adapting Glaser’s (1978) emphasis on basic social and social psychological processes, psychologists can also gain a deeper understanding of psychological processes.” Many areas of interest within psychology involve process yet often

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research and research techniques do not either account for, or accommodate, such process. Ultimately, grounded theory methods facilitate the consideration of processes and are particularly suited to capturing and understanding such processes (Chamberlain, 1999; Mullen & Reynolds, 1978). This is where grounded theory can contribute substantially to advancing understanding within psychology. More specifically, the ability to investigate process is of particular benefit to researching child medical care use as it will enable me to capture the complexities and dynamics of child medical care use and move beyond the static perspective of child medical care use that dominates research in this area, ultimately providing more explanatory power.

Within grounded theory the focus is on theory that is inductively derived from or grounded in the data, hence the term grounded theory. Rather than entering the research investigation with a set of preconceived hypotheses from pre-existing theories that are to be tested in the field, as is usually done in traditional positivist approaches to research, grounded theorists aim to inductively develop from - or ground - a theory of the phenomenon of interest within the data. But it should be noted that although grounded theory is defined as an inductive approach it involves elements of deduction. That is, analysis involves deductively testing hypotheses in the data. Thus, grounded theory involves moving between inductive and deductive thinking, but the overall aim is to use these processes to develop a theory that is essentially derived from, or grounded in, the data.

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The value of approaching a phenomenon such as child medical care use in an inductive manner is that it is an open and flexible approach that enables the researcher to break out of the confines of existing theoretical frameworks (Charmaz, 1995b; Pidgeon, 1997). This means that researchers can enter into and explore the world of the participant in an unrestricted manner, thus not only allowing for the world of the participant to be captured in a less imposing manner but also allowing researchers to attend to how participants, in this case parents, construct their worlds and enabling this to shape the research (Charmaz, 1990). This also allows for discoveries to be made and for the uniqueness of the particular context of child medical care use to be expressed and captured. Further, such an inductive approach enables researchers to develop theories where existing theories may fail or no others exist (Smith & Biley, 1997), and it stimulates reflection about existing theories and concepts that may be being used “beyond their meaningful academic shelf life!” or that are becoming increasingly open to challenge (Backett, 1990, p. 67). Thus, in terms of researching child medical care use such an inductive approach enables researchers to overcome limitations brought on by the more traditional approaches adopted in previous research in this area.

There are a number of practices that are said to ensure and maintain this inductiveness or groundedness: these include delaying the literature review, and developing a specific research question or focus from the field. Firstly, researchers are encouraged to delay reviewing the literature until the analysis is under progress so that the researcher is not influenced by, nor the analysis and

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developing theory shaped by preconceived concepts or theories. But the literature review is not overlooked altogether, rather, the literature is integrated into the analysis during the analytic phase of the research process (Charmaz, 1995b; Stern & Pyles, 1986).

But avoiding the literature prior to analysis is to some extent both undesirable and unavoidable (Chamberlain, 1999; Schreiber, 2001). To begin with, a review of the literature is necessary to get a feel for the area of interest, or to have some background knowledge, to select and develop a broad research question or focus, and because - usually - proposals for funding require this (Chamberlain, 1999; Smith & Biley, 1997). Further, many researchers enter the field with background knowledge in the area. Thus prior knowledge of, or a review of, literature in the area is often desirable and often cannot be avoided. For grounded theory this means that the researcher needs to be aware of and acknowledge the influence of such knowledge. Further, to ensure and maintain the groundedness of the theory the researcher needs to keep close to the data, attend closely to what is happening in the world of the participant, and as Chamberlain (1999, p. 184-185) states "ensure that all aspects of the theory can be justified in the data." Altogether, this means that the researcher can be open to discovery while at the same time remaining informed.

Another technique for ensuring the inductiveness or groundedness of the theory is that of allowing the specific research question or focus to develop from the data (Glaser & Strauss, 1967). This is achieved by entering the field

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with a set of general research ideas or questions that are broad, flexible, and open enough to enable the particular research question or focus to develop as the research process continues. With grounded theory the researcher attends closely to the worlds of the participants and this shapes what is investigated and explored. Relevant issues or theoretical frameworks are not predetermined or imposed upon the participants or the research, but are allowed to develop from the data. Such an approach does not assume to already know what is relevant or central to the worlds of the participants (Glaser, 1978). Ultimately, this allows the theory to be developed from the data, not from predetermined hypotheses or theoretical frameworks (Charmaz, 1995b; Smith & Biley, 1997). In the later stages of theory development the researcher's personal and professional experience and knowledge, and reading of the literature in the area are encouraged to aid in developing the grounded theory. This process is called theoretical sensitivity. Researchers may bring this theoretical sensitivity to the research situation, but they are also encouraged to develop it in the research process (Strass & Corbin, 1990).

Despite the view that researchers should not enter the study with preconceived theories or constructs I do believe that grounded theory studies that do draw on existing theories and concepts demonstrate the contribution that grounded theory methods can make towards elaborating and modifying existing theories and concepts. For example, Vaughn (1992) advocates "theoretical elaboration" which consists of adopting existing theories and further developing them with qualitative analysis. Olshansky (1996) provides an example of how grounded

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theory can be used to build on and enhance existing theory drawing on Vaughn's (1992) concept of theoretical elaboration. Olshansky (1996, p. 395) argues that such an approach produces a theory that "is likely to be more complex and have greater explanatory power than would be true after one study, thus allowing for greater confidence in the theory as a basis for practice." With regards to this issue, I am in agreement with Dey (1999, p. 251) in that "conceptual frameworks can act as guides rather than as prison guards - that prior conceptions need not become preconceptions...". Ultimately, grounded theory can be very useful for opening up and further developing existing theories or concepts, but if the groundedness of these is to be maintained they must be proven relevant or justified within the data (Charmaz, 1995b; Glaser, 1978; Strauss & Corbin, 1994).

Consistent with the social constructionist position within which this study is conducted, it is recognised that "rather than reflecting a *tabula rasa*, grounded theorists bring to their studies the general perspectives of their disciplines, their own philosophical, theoretical, substantive, and methodological proclivities, their particular research interests, and their biographies" (Charmaz, 1990, p. 1170; italics in the original). Thus, the researcher does not walk into the study void of influences from, for example, existing theories or concepts. Rather, such things as the researcher's experience and knowledge play an important role throughout the research process.

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Within the social constructionist position adopted, it is recognised that the researcher is integrally involved in the research process and outcome; he or she is not considered separate or detached from it (Annells, 1997a). Rather, the researcher plays an active part in the research process. Such interaction means that the findings are literally created in the research process (Guba & Lincoln, 1994). This means that the resulting theory is constructed through the interactional process between the data or participants and the researcher, rather than emerging out of - or being discovered in - the data (Annells, 1997a; Charmaz, 1995b; Constain Schou & Hewison, 1998; Henwood & Pidgeon, 1992). Hence the term theory generation or development is preferred to theory discovery or emergence (Henwood & Pidgeon, 1992). Further, the label theory generation or development acknowledges the creative and active process of the researcher (Henwood & Pidgeon, 1992). Ultimately, this means that different researchers may develop different constructions or produce different results from the same phenomenon (Rennie et al., 1988). Overall, as stated by Charmaz (1990, p. 1165) "the social constructionist perspective assumes an active, not neutral, observer whose decisions shape both process and product throughout the research. In short, the research report is also a social construction of the social constructions found and explicated in the data." But in the present study it is also acknowledged that this research relates to, and remains grounded in, the real material world. Thus the socially constructed nature of this research is recognised while also acknowledging the relationship it has to the material world.

In addition to these features outlined above, there are several specific techniques within grounded theory methodology that are valuable not only for developing theory or building conceptual analysis and theorising process, but in themselves as tools that can be usefully applied when conducting qualitative research, and in particular, in the present study. To begin with, in terms of data collection methods, grounded theory has most often been equated with qualitative data collection methods. Data that are appropriate for grounded theory studies can be collected through a number of methods including observation, interviews, and documentary materials (Charmaz, 1995b; Corbin & Strauss, 1990; Dey, 1999; Henwood & Pidgeon, 1995; Stern & Pyles, 1986; Strauss & Corbin, 1994). The use of these methods means that researchers can enter the world of the participants in a way that can not be achieved with quantitative methods. Ultimately, this provides researchers with the opportunity to create theory in areas that are difficult to access using quantitative methods, and to obtain the rich detailed data that are required for developing a grounded theory (Charmaz, 1990; 1995b). With regards to the present study, the use of a qualitative data collection method means that I can approach the topic in an unrestricted manner which not only fosters an element of discovery and allows me to explore the context of child medical care use, but also allows for the exploration of parental perspectives and understandings surrounding child medical care use and the development of factors, constructs, or theory that are grounded in, and capture, the worlds of the participants.

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A technique of grounded theory methodology is that of intertwining data collection with data analysis. This intertwining process contrasts with traditional deductive approaches to research where the researcher collects all the data before commencing the analysis. In grounded theory methodology, rather than collecting all the data before the analysis takes place, researchers are able to collect further data as the analysis progresses. In this way researchers are not restricted to the data collected before the analysis investigation. With regard to data collection, participants are not selected according to representativeness or randomness. Variables such as ethnicity, age, gender, or socioeconomic status are not used as the basis for sampling unless they are part of the research question or focus, or until they are shown to be relevant in the analysis (Corbin, 1986b). Rather, in grounded theory, participants are sampled according to the potential contribution they can make towards the developing theory (Fagerhaugh, 1986). Initially, the sample is chosen according to where the phenomenon under focus exists (Chenitz & Swanson, 1986; Glaser, 1978). From then on sampling is guided by the developing and evolving theory. This sampling strategy is called theoretical sampling.

The benefit of the intertwined process of data collection and analysis is that it allows the researcher to identify and eliminate gaps in the emerging theory, to follow up on interesting and unanticipated avenues and in the appropriate places, to keep the data collection focused, and to change the focus of analysis strategies accordingly (Chamberlain, 1999). This enables the researcher to capture all potentially relevant aspects of an area of interest, such as child

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medical care use, and to examine this area thoroughly. This approach also enables researchers to maintain the groundedness of the theory by allowing them to make changes throughout the research process that ensure that the researchers can carefully attend to the worlds of the participants and that the data reflect what is happening in the field (Chamberlain, 1999; Charmaz, 1995b; Corbin & Strauss, 1990). Further, this intertwined process increases insight into, and sensitivity to, the emerging theory (Chamberlain, 1999; Glaser, 1978). Overall, because researchers are not restricted by decisions made before the investigation, this approach allows for an element of flexibility and openness that is often demanded in research investigating child medical care use.

Techniques used to determine sample size in grounded theory studies are also of value for conducting qualitative research within psychology. In grounded theory the size of the sample is not decided before the study begins. Rather, data collection continues until the point of saturation is reached. Saturation refers to the point where there is replication in the data and further data collection yields no new relevant information that can expand on the theory (Morse, 1995). Unfortunately, as argued by Dey (1999), the term saturation can be misunderstood to imply that data sources have been exhausted when, in fact, this cannot be the case. Dey (1999, 117), argues that “a decision not to collect further data can be no more than a guess (albeit more or less well grounded) that such an investment is no longer worth the trouble given the likely (theoretical) reward. We certainly cannot predict accurately whether the very next round of data collection (or even a further trawl through our current

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dataset) might throw up something that suggests an important modification or even a new perspective.” In accordance with this argument I choose to use the term saturation to refer to “the stage at which categories seem to cope adequately with new data without requiring continual extensions and modifications” (Dey, 1999, p. 117).

Saturation ensures that the data collected are complete, full, and rich, that there are no gaps in the theory, and that there are enough data to “build a comprehensive and convincing theory” (Morse, 1995, p. 148). Consequently, data collection ceases when it is considered that sufficient data have been obtained to achieve this. In summary, saturation ensures that a phenomenon such as child medical care use has been thoroughly explored and a full and detailed understanding of child medical care use is achieved.

The principal means used to analyse data in grounded theory methodology is the constant comparative data analysis method. This procedure involves continuously and systematically sifting through the data and analysing them for similarities and differences that exist, endeavouring to develop a grounded theory or construct theory from the data. Briefly, in constant comparative analysis the data are compared and commonalities among them are grouped conceptually into codes. Codes are then compared and similar codes are clustered into categories. Categories are then developed further and refined. As categories are developed further, conceptual relationships between them are established, and patterns of relationships are then developed and categories are

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integrated. This process of constant comparison is intricately linked in with theoretical sampling and memo writing and diagramming. As the analysis continues it becomes more conceptual and abstract, and more clarified and refined. Finally, the analysis is then integrated around a core category (Corbin, 1986b). A core category is the category that “represents the central phenomenon of the study” (Corbin & Strauss, 1990, p. 14). It logically links all the categories, all other categories are related to the core category, and accounts for the variation in the phenomenon (Corbin & Strauss, 1990; Glaser, 1978).

Within grounded theory studies usually only one core category is developed. An analysis may identify more than one core category, but proponents of grounded theory suggest that the researcher select and report only one (Corbin & Strauss, 1990; Glaser, 1978). Strauss and Corbin (1990, p. 121) argue that “it is essential, however, to make a choice between them to achieve the tight integration and the dense development of categories required of a grounded theory.” However, in agreement with Dey (1999) I argue against the development of a single core category. Dey argues (p. 111-112):

Taking one core category as a fulcrum for theory may also mislead if it excludes or underestimates the role of other important factors. The research may result in a single product rather than offer a menu of possibilities. Selecting a core category seems to involve the elimination of alternative accounts - for these are relegated to future reports. It suggests that there is no place for conflicting and contradictory explanations, which

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may be more or less supported by the available evidence. The logic of the analysis permits only one positive conclusion: that the core variable has emerged with some explanatory power. But it does not seem to permit the explanatory power to be pitted against the potential of alternative explanations.

Accordingly, the aim of the present study is not to develop a core category that encapsulates child medical care use. Rather, the aim is to develop a rich and detailed understanding of this phenomenon that is grounded in the data.

Overall, the value of the constant comparative data analysis method is that it provides a systematic set of procedures that aid the researcher in handling qualitative data and helping to structure the analysis, thus enabling the researcher to make sense of substantial amounts of data (Maykut & Morehouse, 1994). Further, this approach to data analysis promotes conceptual and theoretical development and ensures exploration of the full complexity and diversity of the data (Pidgeon, 1997). Finally, as Artinian (1986, p. 18) states, "the method of constant comparative analysis used to generate grounded theory makes it possible to progressively focus the research as the data becomes clearer." Overall, the constant comparative data analysis method aids the researcher in developing a thorough understanding that is developed from - or grounded in - the area of interest, such as child medical care use.

Integral to grounded theory methodology is the use of memos and diagrams. Essentially, memos and diagrams are a way of capturing ideas that emerge throughout the research process and providing a visual representation of the developing theory. In particular, information and thoughts on aspects of the research are recorded in memos, including details of participants, interviews, and the analysis. Writing memos and constructing diagrams is ongoing throughout the research process. The researcher begins as soon as the data have been collected and finishes when the study has been written up. As a result, memos and diagrams evolve as the research progresses, and are continuously modified and updated throughout the data collection and analysis process.

The use of memos and diagrams serves a number of beneficial functions, particularly for theory development. For instance, they enable the researcher to preserve and keep track of analytic ideas, they help to clarify the analysis and reveal any gaps, they stimulate ideas and questions, they make the developing theory easily comprehensible, they encourage playing with ideas, and finally, they aid in the writing up of the theory (Glaser, 1994; Rennie et al., 1988). Further, both memos and diagrams help the researcher to think abstractly about the data or gain “analytical distance” from the data (Strauss & Corbin, 1990). The use of diagrams, in particular, enables the researcher to manipulate the data in a way that he or she is unable to do with memos. Diagrams also “enable the analyst to visualise the logical flow of ideas” (Corbin, 1986a, p. 177).

Ultimately, memos and diagrams assist in sharpening analysis and theory development.

In summary, grounded theory procedures provide a systematic approach to qualitative data analysis. They provide a way of structuring and organising the research process and analysis in a manner that enables researchers to conduct their research in an efficient and effective manner (Charmaz, 1995b). Further, grounded theory procedures enable researchers to develop a theory or rich conceptual analysis, capture and theorise complex processes, and conduct research in an open and flexible manner that allows them to enter into and explore the worlds of the participants and to make discoveries. With regards to the present study, grounded theory methods provide a means of investigating parents' understandings, the complexities of child medical care use - including conceptualising this phenomenon as a complex process - contextualising child medical care use, fostering discovery, and capturing the lived world of the participants. Overall, the use of grounded theory methods will enable me to explore parents' talk surrounding their treatment-seeking during episodes of childhood illness and their use of preventative child medical care services, and to develop a rich and dense understanding of their use of these child medical care services that attempts to fill the gaps in current understanding in this area.

## **CHAPTER FIVE**

### **THE RESEARCH PROCESS**

Given the arguments presented in the previous chapter for the value of grounded theory methods for researching child medical care use, I have adopted a number of grounded theory strategies for this investigation. Altogether, the research process that shaped this investigation involved selecting and recruiting participants, conducting individual semi-structured interviews, considering the ethical issues involved, and analysing the interviews with the constant comparative method of data analysis. In this chapter I outline this research process.

#### **USING GROUNDED THEORY**

As mentioned earlier, I have chosen not to use grounded theory in its 'pure' form. Rather, I have drawn on those aspects of grounded theory that seemed useful and valuable for this study. One of the primary aims of grounded theory is theory development and there are various procedures and practices that

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facilitate this. By adopting these practices I hope to move beyond a descriptive account of child medical care use to developing a theory that better captures the complexity of this phenomenon (Chamberlain, 1999). It is hoped that this will facilitate the development of a rich and deep understanding of child medical care use that serves the need for a framework of action to improve child health within New Zealand. Various grounded theory methods facilitate the consideration and investigation of processes. The ability to investigate process is beneficial to researching child medical care use as it will serve to aid a move beyond a static perspective of child medical care use (Chamberlain, 1999; Mullen & Reynolds, 1978). It is also hoped that it will aid in capturing the complexities and dynamics of this phenomenon. The inductive nature of grounded theory provides an open and flexible approach that allows for the researcher to enter into and explore participants' reports of their experiences and allows for the uniqueness of the context of child medical care use to be expressed and captured (Charmaz, 1995b; Pidgeon, 1997). The use of a qualitative method means that I can explore child medical care use in an unrestricted manner facilitating the development of a rich and dense understanding of this area (Charmaz, 1990). This not only fosters an element of discovery, it also allows me to explore the context of child medical care use (at least more so than in a quantitative study). Further, this allows for the exploration of parental perspectives and understandings and the development of a theory that captures, and is grounded in, the worlds of the participants. Finally, with grounded theory the research process and analysis is structured and organized with the use of various tools and methods such as the use of

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memos and diagrams, constant comparative analysis and saturation. Such procedures may aid the researcher in exploring the complexity and diversity of the data and to achieve a full and rich understanding of the phenomenon being investigated, such as child medical care use (Pidgeon, 1997). I have highlighted here my reasoning behind adopting a grounded theory approach and I will now discuss the specific details of the research process undertaken in this investigation.

### **PARTICIPANT SELECTION AND RECRUITMENT**

A range of parents with a variety of perspectives, experiences regarding childhood illness and illness management, and child medical care practices took part in this study. This included parents who worked full-time, part-time, or who did not work at all, parents who used a variety of treatment methods on their children (such as those who regularly used alternative medicines to parents who did not), and parents who fully, partially, delayed or decided against immunising their children. Such broad sampling allows for a relevant and potentially information-rich supply of data while also allowing for an unrestricted exploration of the research focus. This facilitates the development of a rich and broad-based understanding of child medical care use that arises from the reported experiences of the participants. Further, as with the inductive nature of the grounded theory approach this aids in the development of a specific research question that arises from the data.

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To provide a focus for this study, I decided to concentrate on exploring child medical care use for children under the age of 6 years. This age group was chosen for two reasons. Firstly, focusing on children under the age of 6, meant that parents' accounts would reflect current issues and concerns prevalent within New Zealand today. This is particularly relevant when considering the impact of policy on parental issues surrounding child medical care, in particular, the policy for free doctors' visits for children under the age of 6 years. Secondly, focusing on children under the age of 6 years provides a focus on a particular developmental stage and the medical care decisions and practices associated with - and the services available for - children of this age group. Consequently, the participant selection criteria were relatively open and broad consisting of parents or guardians with at least one child under the age of 6 years. Participant selection was restricted to the Palmerston North.

In accordance with grounded theory, participants were sampled according to the potential contribution they could make towards the analysis. Initially, an open process of soliciting participants was adopted. Once I started coding the interview transcripts I was able to sample more participants. In contrast to grounded theory methodology, theoretical sampling was not conducted. Rather, saturation was achieved without the need to theoretically sample. I believe that this was because each interview contained plenty of variation. That is, within a single interview several episodes of childhood illness would be discussed, that varied along many dimensions and factors. This enabled me to

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refer back to various interviews to fill in the gaps and achieve the saturation needed in the analysis.

A number of different strategies were used to recruit participants. Firstly, the participants were recruited through advertisements placed on notice boards at crèches, Plunket rooms, in a crèche newsletter, and across a parent email discussion list. This last form of advertising proved to be the most fruitful. These advertisements briefly outlined the aim of the study, the criteria for participation, and what participation would involve. Those interested in taking part were invited to contact the researcher for further information. Participants were also recruited through snowballing. Here associates and participants were asked if they had any friends who would be interested in taking part in the research. Finally, 2 participants were recruited through opportunist encounters. I happened to meet two parents who, upon hearing about my research, expressed an interest in taking part. Together these different recruitment strategies were used to enhance my chances of recruiting participants and to achieve broad sampling. Overall, the participants consisted of 20 parents or guardians; 2 fathers and 18 mothers.

After indicating their interest, potential participants were given an invitation letter and information sheet (Appendices A and B). On the occasions when snowballing was used, participants passed on these documents to personal contacts who indicated an interest in the research. The purpose of these documents was to introduce the researcher, explain the research in more detail,

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and inform the prospective participants of their rights should they take part in the research. Those who were still interested in participating, or who wanted to find out more about the research, were asked to provide their name and phone number either at the bottom of the invitation letter and to send it back in the freepost envelope provided, or via email. Those who replied were then contacted by telephone to discuss the study further and to answer any questions. A time and place for an interview that was suitable for the participant was then arranged.

### DATA COLLECTION

The data were collected through individual semi-structured interviews. Semi-structured interviewing involves the use of an interview guide or schedule that is developed around a list of topics or issues relevant to the research focus to be explored in each interview. Within this guide the topics are not arranged to be discussed in any particular order nor is the wording of questions predetermined.

Semi-structured interviewing was considered the most suitable data collection method in the present study for a number of reasons. Firstly, the open-ended nature of this approach means that the participants are able to express themselves in their own words and to do so at length. That is, participant responses are not restricted in any manner. The advantage of this is that it

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encourages full, deep, and rich accounts and it ensures that the participants' accounts are put into context.

Secondly, because the wording and ordering of questions are not predetermined questions are allowed to flow from the immediate interview situation, and for the researcher to be flexible and spontaneous, thus facilitating a conversational style interview. This is beneficial as it enables the interviewer to be highly responsive to the individual interview situation, and it ultimately facilitates establishing and maintaining rapport and in-depth communication (Patton, 1990).

Thirdly, the semi-structuredness of this approach means that the interviewer is able to freely explore, probe, and follow up on participant responses in the direction appropriate for each particular participant. This enables the clarification and in-depth exploration into particular issues or topics (Patton, 1990). The openness of this approach also means that participants are able to talk about issues that are salient to them, within the focus of the research. That is, the participants are given the freedom to talk about issues that are of pertinence to them, as opposed to those salient to the researcher only.

Further, semi-structured interviews allow for an element of discovery. The interview guide is just that, a guide. It is not intended to dictate what issues are, and are not, covered in the interview (Smith, 1995). Rather, although the interview is constrained by the research focus, the interviewee is free to talk

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around those issues raised by the interviewer and to introduce other material. Ultimately, this may lead to the emergence of new theoretical avenues not previously considered by the researcher. Smith (1995, p. 17) claims that "these novel avenues are often the most valuable, precisely because they have come unprompted from the respondent and, therefore, are likely to be of special importance to him or her". Further, semi-structured interviewing is flexible enough to allow the researcher to investigate interesting avenues that arise during the interview (Smith, 1995), ultimately allowing for great flexibility in coverage. Finally, and on a more practical level, the use of an interview guide enables the interviewer to make the best use of the limited time available in an interview situation (Patton, 1990).

Overall, features of the semi-structured interview are ideal in aiding researchers to achieve rich, detailed data. Additionally, the openness and flexibility that it provides for the researcher work well with, and complement, the openness and flexibility of grounded theory methods and the aim to achieve an understanding that is grounded in the data. Further, the semi-structured interview is compatible with the social constructionist approach in that it reflects "an awareness that individuals understand the world in varying ways", and enables the researcher to enter into the world of the participants facilitating understanding of participant meanings or constructions through the use of their own words (Berg, 1995, p. 33).

Initially the interview guide was developed after reviewing the media for pertinent issues, informal talks with parents/guardians, and through brainstorming. Additionally, in contrast to a more strict grounded theory approach a brief literature review was also conducted to inform the interview guide. Two pilot interviews were also conducted to help develop the interview guide and to practise interviewing techniques.

Although semi-structured interviewing was conducted, the level of structure of the interview varied throughout the research process. At the beginning of the research process the interviews were less structured in an attempt to allow for discovery. At this early stage in the research, consistent with a grounded theory approach, more structured guidance would have been counterproductive to such discovery. As the research progressed the interviews became more structured in certain areas, while remaining less structured in less developed areas, to focus on theoretical leads or discoveries and to eliminate gaps in the developing analysis.

At the beginning of each interview, time was spent reiterating the nature of the study, participants' rights, and what the interview was going to cover. Participants were encouraged to ask any questions at this point. Time was also spent chatting informally and building rapport. After a couple of interviews, I got the feeling that some parents (and some even expressed it) felt that talking about everyday childhood illness experiences was not particularly important and that I must be interested in more significant illness episodes, despite my

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having explained this at the beginning of the interviews. Cunningham-Burley (1990) had a similar occurrence in her research investigating mothers' beliefs about and perceptions, of their children's illnesses. Cunningham-Burley found that for these mothers, everyday illness experiences were not considered relevant compared to the more significant illness episodes they had experienced. To remedy this I encouraged parents to feel that what they had to contribute was of relevance to the research and that I could learn a great deal from their contribution - particularly on matters regarding everyday childhood illnesses. An attempt was also made throughout the interviews to create and maintain an informal atmosphere and to encourage participants to talk at length.

Before the interviews took place, participants were also asked to sign a consent form agreeing to take part in the research under the conditions outlined in the information sheet (Appendix C). The interviews were held in a setting that was both suitable and accessible for the participants. The majority of the interviews were conducted in the participants' homes, but three took place in an interview room within the School of Psychology building. Each interview lasted approximately an hour and a half. Initially, participants were informed that interviews would take approximately 1 hour, but they were encouraged to talk for as long as they liked, or was possible. The interviews were audio tape-recorded and brief notes were taken during the interview.

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The interviews were transcribed verbatim. After the initial transcription, I listened to the tape and read through the transcript to correct any mistakes in the transcription, to familiarise myself with the interview data, and to pick up on the verbal cues - such as sarcasm - which are missed in transcription. I transcribed half of the interviews myself and the other half were transcribed by a professional typist after funding was received to do so.

### **ETHICAL CONSIDERATIONS**

The present study was conducted within the ethical guidelines of the code of ethics of the New Zealand Psychological Society and the Massey University Human Ethics Committee and formal approval was obtained from the Massey University Human Ethics Committee. Within these ethical guidelines ethical concerns, such as gaining access to potential participants, informed consent, anonymity, and confidentiality issues, were addressed.

### **GAINING ACCESS TO POTENTIAL PARTICIPANTS**

It was not envisaged that gaining access to potential participants would raise any ethical issues. However, when I asked a Plunket nurse for permission to attend a child health check-up clinic for the purpose of recruiting participants my request was declined due to her concern that if I were to approach parents directly, they might have felt pressured to participate, despite participation

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being voluntary. Fortunately, the nurse did agree to place my posters advertising for participants strategically around the check-up rooms.

### **INFORMED CONSENT**

To ensure that all participants were fully informed about the research objectives, the research process, and their rights as participants, potential participants were given an information sheet detailing aspects of the study and their rights during the course of the research. This informed potential participants of the purpose of the research, what participation would involve, the use to which research data would be put, that brief quotes may be used in reports and publications pertaining to the research, and that the study was funded by the Health Research Council of New Zealand. Prior to giving their informed consent, potential participants were provided with the opportunity to discuss the study with me and/or my supervisors if they so wished.

The rights of potential participants included the right to decline participation, to refuse to answer any particular question, to have the tape recorder turned off at any point during the interview, to withdraw from the research at any time, to ask any questions about the research at any time during participation, and to be given access to a summary of the findings when the research was concluded. With regard to these points, the tape-recorder was switched off frequently during the interviews, but this was due to the need to attend to a child or baby. There were no cases of participants' refusing to answer any questions, nor of

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anyone withdrawing from the study. All of the participants requested a summary of the findings.

After reading the information sheet and prior to the interviews taking place, participants were required to sign a consent form agreeing to take part in the research under the conditions outlined in the information sheet. Consent was also sought for the interview to be audio-tape recorded and participants were asked to indicate whether they would prefer to have the interview tape and transcript returned to them or for these to be destroyed upon completion of the research. All participants chose to have the interview tape and transcript destroyed.

#### **ANONYMITY**

To protect the anonymity of the participants, pseudonyms are used to identify direct quotations in all reports and publications pertaining to the research. Identifying information in the interview transcripts, such as the names of children, were also changed. Further, the names of health professionals or health clinics were excluded to protect their privacy.

#### **CONFIDENTIALITY**

The confidentiality of the participants was maintained by identifying the tapes and transcripts by code only and storing these in a secure area along with the

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signed consent forms and contact details of the participants. Confidentiality was maintained also by ensuring that these items and information were available only to the researcher and supervisors. Further, the typist transcribing the interviews was required to sign a confidentiality agreement prior to receiving the interview tapes.

### OVERVIEW OF THE DATA ANALYSIS

Consistent with the grounded theory approach the constant comparative method of analysis was adopted to analyse the data. The analysis involved a number of processes that included developing codes, memo writing, constructing diagrams, developing categories, and building these categories and their relationships. The computer programme Q.S.R NUD\*IST (Non-numerical Unstructured Data Indexing, Searching and Theorising) was used to aid in the analysis process.

### **CODING**

The analysis initially involved conceptualising and categorising the data according to the more 'pure' grounded theory strategies – constant comparative analysis. To begin with, this involved examining each interview transcript, line by line, making comparisons between and among parents' accounts and creating a conceptual label or code for each potential indicator of a concept. To

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aid in the identification of such phenomena, questions such as “what is this an example of?” and “what concept does this represent or indicate with regards to seeking child medical care?” were asked of the data. I aimed to use conceptual labels for codes, although at times I also used in-vivo (a label derived from the participants’ own words) and descriptive labels, but overall I attempted to use a label that best conceptualised or represented the concept identified. Concepts were continuously compared for similarities and differences and those that were similar were given the same label or code. In this initial conceptualising process, the data were coded in every way possible; coding was unrestricted. For example, concepts were sometimes coded under more than one label and concepts with even the smallest difference were placed under different codes. The interview transcripts were continuously coded and recoded, and the codes were continuously revised and refined as the analysis progressed. Examples of two concepts that were expressed by parents as playing a major role in seeking medical treatment were that of ‘the risk of medicines’ and ‘having to work’. These concepts were initially coded at the beginning of the analysis and became useful later on in theory development.

## **CATEGORISING**

Categories and subcategories were formed by comparing these codes and grouping together those that were similar or that referred to the same phenomenon or concept and by asking questions of the data such as “what category does this concept indicate or belong to?” and “what is going on for

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these parents here with regard to child medical care use?" My aim during categorising was to achieve a more abstract status than that achieved with coding and to focus on identifying processes. Each category was given a name or label that best captured the nature of the category. Initially, categorising was unrestricted, that is, as many categories as seemed relevant were developed, and codes were assigned to as many categories as applicable. The categories were then continuously revised and refined upon reexamination, and as old codes were modified and new codes emerged through further analysis. Codes that did not fit into a particular category at the time were allocated to a miscellaneous pile to be reviewed later as the analysis progressed.

As the categories and subcategories were generated, the data, codes, and categories were continuously examined and reexamined for the purpose of obtaining a full description to further build and clarify these categories. Further development of these categories involved testing them and searching for the boundaries of, and variation within, the categories. This was achieved through making comparisons between and within parents' accounts, codes, and categories. This process was aided by the fact that each interview brought with it plenty of variation. Throughout a single interview several episodes of childhood illness, which varied along many dimensions and factors, were discussed. Coding and categorisation continued until saturation was reached. Further participants were recruited and interviews were conducted in order to achieve this. An example of a category developed in the present study is that of 'dealing with role conflict'. It was revealed that competing priorities and

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demands such as 'having to work' were problems resulting from the various roles that these parents fill in their daily lives and the obligations that each of these roles entails. These roles consisted of being a parent, housewife or househusband, or a career person. Other categories developed in the analysis included 'being a "good parent"', 'preserving child health', 'fulfilling social roles', 'the immediate environment', and 'individually and socially shared understandings'. Subcategories developed were 'doing the right thing', 'limiting risk', 'dealing with role conflict and barriers to care'.

### **THEORY DEVELOPMENT**

The next phase of the analysis involved formulating hypotheses regarding the conceptual relationships and patterns between categories and subcategories based on the comparisons made. As these relationships and patterns were generated, the analysis progressed with the testing of these relationships. An example of such a hypothesis is - 'parents' decisions regarding treatment seeking involve a negotiation between 'preserving child health' by avoiding the risk of antibiotics, for example, and 'being a "good parent"' by taking the child to the doctor. Hypotheses were revised or modified as needed and testing continued until hypotheses were repeatedly verified in the data, ultimately resulting in a complex conceptualisation of child medical care use. Consistent with the grounded theory approach there was continual movement between inductive and deductive thinking with the inductive development of

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hypotheses from the data and the deductive testing of these hypotheses in the data.

In addition to asking questions such as “what is this an example of?”, “what concept does this represent or indicate?”, and “what category does this concept indicate or belong to?”, a number of other questions were asked to aid in the analysis. In particular, throughout the analysis process I remained tuned in to looking for processes within the data by asking questions such as “what process is at work here?” or “what are parents doing here?” and trying to keep the codes and categories active. Additionally, I continuously asked the data “what is going on here for these parents or what is this all about?” to aid in the development of a specific focus. Consistent with the inductive nature of the grounded theory approach the specific research focus was allowed to develop from the data. I initially approached the data with a broad and flexible focus on exploring how parents construct their child medical care use. Throughout the analytic process it became evident that for these parents, child medical care use consists of two distinct, but similar, processes regarding seeking medical treatment and preventative care comprising facing and negotiating various issues and concerns. These processes have been divided into two chapters titled ‘constructing child medical care use: seeking care’ and ‘constructing child medical care use: seeking health preservation’. As the research progressed, delving into and exploring these issues and concerns became the key focus with the aim of developing a rich understanding of child medical care use that encapsulated the complexities of these processes. In this way the specific

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research focus was shaped by the data, as consistent with the grounded theory approach. At variance with a 'strict' grounded theory approach a core category was not developed from this analysis. In Chapter Four I argued against the development of a single core category and instead argued for the aim of this study as not one of developing a core category but that of developing a rich and detailed understanding of child medical care use that is grounded in the data. In this study the analysis resulted in the development of a model depicting child medical care use as a socially based decision-making process that takes place within a social context in which child health, illness, and disease are medicalised, and parents struggle between individual concerns (such as the risk of medicines and competing obligations from fulfilling social roles) and social concerns.

As with the grounded theory approach, in the later stages of analysis I sifted through the literature to aid in developing theoretical sensitivity. Further, ideas generated during this analysis process were put into memos and developed into diagrams. These memos and diagrams were continuously constructed and revised throughout the research process with the aid of NUD\*IST. Writing memos and constructing diagrams began as soon as the analysis started and they become more complex and conceptual; evolving as the analysis progressed. Together, these memos and diagrams served to aid in the analytic processes by facilitating the conceptualisation and visualisation of the developing analysis.

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Further analysis was achieved during the writing up phase of the analysis. Charmaz (1990, p. 1169-1170) writes that “the researcher gains further insights and creates more ideas about the data while writing hence, writing and rewriting actually become crucial phases of the analytic process. Through writing and rewriting, a researcher can identify arguments and problems, make assumptions explicit and sharpen the concepts (Becker, 1986)...writing and rewriting certainly foster analytic clarity. These processes also prompt gaining more theoretical comprehensiveness and precision as the researcher grapples with increasingly more abstract theoretical questions and hones his or her responses to them.” Further, during the writing process, links with my analysis were made with the literature on child medical care use; comparing how and where it fits in with my analysis, thus locating my analysis within the context of existing theories and research in this area.

In conclusion, the primary objective of this research was to provide an investigation of child medical care use that fills the gaps in current understanding in this area. Various research strategies were adopted to help achieve this. A sample of parents, recruited through a variety of techniques, took part in individual semi-structured interviews. Through the use of the constant comparative method of data analysis the interview data were conceptualised and categorised, relationships between these categories were established, and a complex conceptualisation of child medical care use was produced. Overall, the aim of the research strategies adopted in this study and

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outlined in this chapter was to facilitate the development of a rich and detailed understanding of child medical care use.

**CHAPTER SIX**

**CONSTRUCTIONS SURROUNDING THE UTILISATION OF CHILD  
MEDICAL CARE**

In chapter four I argued for the importance of recognising, along with the material or physical reality, the socially constructed nature of the utilisation of child medical care use and the objects surrounding this, such as childhood illness. Accordingly, the aim of this chapter is to identify and explore the social constructions surrounding child medical care use that are drawn on in parents' accounts. The analysis revealed that these parents draw on diverse and interesting constructions regarding the child, the parenting role, the medical profession, medicines, and childhood illness and disease. These constructions are complex and contradictory and warrant description and discussion.

## CONSTRUCTING CHILDREN

As can be expected when talking about utilising child medical care services, children are frequently the central feature of parents' talk. Within their accounts the parents in this study talk about children in various and often contradictory ways that differentiate them from adults. In particular, parents construct children as different from adults in two contrasting ways; as strong and hardy, and fragile. In their conversations parents often describe children as resilient and tough in terms of fighting, and recovering from, illness. Quotes from Lucy and Annette provide examples of such talk. Firstly, Annette compares the greater ability of children to recover quickly from an illness to that of adults. Additionally, Lucy defends her decision not to take a sick child to the doctor by drawing on her understanding of the ability of children to "ride out" illnesses, such as colds, without the need for medicines. Such talk establishes children as strong and hardy and, in doing so, legitimises Lucy's decision not to take her ill child to the doctor.

**Annette:**

Grown-ups and children are different. They get sick faster and stuff like that. But they also heal faster, you know, like after the vomiting us grown-ups are sitting in the lounge room for a couple of days and the children are out playing like nothing happened.

**Lucy:**

Um, generally colds usually, they get colds periodically, the strongest is they'll get some Pamol out of me, usually. I just think a cold's a cold, and my doctor's not much fussed on cough mixture for kids. He doesn't necessarily believe in

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that so I don't give them that either. There's no great need for that, so yeah, then usually they just ride it out themselves....you know given a bit of time they'll heal it themselves.

In addition to describing children as resilient and tough, parents also describe children as particularly vulnerable and defenceless in terms of their underdeveloped bodies and susceptibility to illness. Children are also described as "pure" and as having "little bodies". Evidence of this is apparent in the quote above by Annette when she talks about children getting sick more quickly than adults. Additionally, Jo talks about her child's underdeveloped immune system and how this causes her anxiety with taking her child to crèche and exposing him to various illnesses. Further, Sue draws on a description of children as having little bodies to defend her caution regarding the use of conventional medicines. Such talk establishes children, in contrast to strong and hardy, as fragile and, in doing so, legitimises Sue's decision regarding medicine use. Within Sue's account there is also evidence of a construction of medicine use as involving risk.

**Jo:**

With crèche I've got a theory that they get exposed to a whole lot of things in crèche which I think they're too little to handle...they're so little at 6 months and I don't think their their systems are strong enough to cope with it...But especially with little young children and babies. I don't think their immune systems are strong enough to cope with all those.

**Sue:**

I don't use a lot of Pamol. I just use it when they're obviously really in pain. I'd rather distract them with something else or help them some other way if I

can. So anything like that I don't like putting into their little bodies, even if it's only Pamol.

Constructing children in two contradictory ways as strong and fragile, and alternating between these constructions, enables parents to variously present medical care use as either necessary or unnecessary. In doing so, parents are able to defend their decisions concerning child medical care use. This allows for the resolution of these two contradictory constructions, in that one or the other can be drawn on to defend parents' decisions in a manner that presents parents as caring for children in the best possible manner.

As can be seen in the quotes given above, parental constructions of children in these two contrasting ways - as strong and hardy, and fragile - relate to parental understandings of the human body, in particular, the child's developing immune system. This reflects the predominant focus on, and construction of, children as biological entities or biological bodies.

Parental discussion surrounding childhood illness, disease, and medical care and medicine use is characterised by talk that focuses on the child's body and, in particular, immune system - emphasising the biological nature of children and reducing children to biological or physical features. Such talk constructs children as predominantly biological entities and biological bodies. This construction is evident in the following quotes from Gill, Annette, and Emma. Firstly, in defending her decision not to use alternative medicines, Gill draws

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on an obligation that she feels towards looking after the bodies of her children. Secondly, when talking about why she has chosen not to immunise her children, Annette draws on her concern for the child's under-developed immune system to provide a defence for her decision. Finally, Emma draws on her understandings of, and concern for, the child's immune system to defend her caution regarding the use of antibiotics and her belief in giving a sick child time off school. Also evident within these accounts is a hint of the construction of the role of the parent as involving an obligation towards caring for children.

**Gill:**

I feel that I just look after these children and therefore I should seek. I should not experiment...which I feel it's a little bit experimental. I think if they want to become vegan or homeopathic, you know, as adults that's their business, it's their bodies. But at this point I think I just look after their bodies so therefore I wouldn't feel confident in doing that.

**Annette:**

I don't know what I'm going to do once my daughter gets older and my boys get older. Because if they're not exposed to certain things they might get them later or she might catch rubella when she's pregnant, you know, so I'm on the fence. I don't know what to do. But if I choose to do it later I can at least be comforted that their bodies have developed. I have a problem giving it to their under-developed immune system.

**Emma:**

And I actually go along with my doctor's view that as few antibiotics as possible is beneficial to their immune system. So, yeah, I try not to have them treated as much as possible. The other thing is that when they're sick, even a little bit off colour, I'm quite comfortable at having them off school. And that's a luxury that I have because I'm not working. And my husband and I have

agreed that until the children are older it's important to have somebody with flexible time to be able to cater to all those little things. But it gives their immune systems a chance to work.

Referring to children as biological bodies enables these parents to legitimate their decisions regarding health care use, or non-use as the case may be, by highlighting the extent of the effects of antibiotics upon children. Further, by adopting biomedical terminology, drawing on biomedical concepts and explanations and ultimately placing or framing their decisions within a biomedical framework of understanding parents are also able to legitimate their decisions. Such talk not only enables parents to present themselves as well informed and knowledgeable regarding the workings of the child's body, it also enables parents to present themselves as acting from a legitimated knowledge base and, thus, as doing the best thing for the child's health and well-being.

In summary, within their accounts these parents construct children in three different but interrelated ways as strong and hardy, and fragile, and more generally as biological bodies. Overall, these constructions reflect the diverse and flexible nature of parental talk regarding children. This diversity and flexibility enables parents to legitimate and defend their actions and decisions concerning child medical care use, in various ways.

**CONSTRUCTING THE PARENTING ROLE AND THE "GOOD PARENT"**

When talking about episodes of childhood illness and utilising child medical care services, these parents frequently refer to their role as a parent and what it entails. In doing so these parents construct the parenting role in a certain manner along with an ideal of a "good parent". Within their accounts parents talk of their role as a parent as primarily involving an "obligation" or a "duty" to do the right thing or what is best for their child. For example, ensuring that their children "turn out right", that they are in relatively good health, and that they receive the best possible medical care when needed. Such talk constructs the parenting role as entailing a moral obligation or responsibility towards caring for and protecting the child and the child's health and well-being. In the following quotes, when Gill and Caryl talk about their reasons for taking an ill child to the doctor they describe their duties, as parents, towards their children. In doing so both Gill and Caryl establish their roles as parents as involving a primary moral obligation towards looking after the health of their children.

**Gill:**

I don't believe that children belong to people and so therefore as their minder, caregiver, mother, it's my duty to seek the absolute best health care for them.

**Caryl:**

You've gotta be the advocate for your child. You've gotta look after their health. You can't, yeah, let anything dreadful like that happen to them if you can avoid it. Yeah.

The parenting role is not only constructed as involving a primary moral obligation towards caring for and protecting their own child's health and well-being. Rather, it is also constructed as involving a wider moral obligation or responsibility towards the health and well-being of other children within the community. This reflects a construction of the parenting role as wider than that of just being an individual parent. That is, this construction also encompasses being a parent within a community or as a community member. For these parents this turns caring for their own child's health and illness care into a social issue; an issue of social responsibility. Evidence of this wider construction of the parenting role is apparent when these parents talk about preventing the spread of illness by refraining from allowing their sick child to play with other children. Further evidence is provided in a quote from James when he justifies his decision to have his children immunised by referring to a concern for the need for every child in the community to be immunised to prevent disease epidemics. Within this account, James highlights his moral obligation as a parent and a parent who is a member of the community in caring for and protecting the health and well-being of children within the community. Additionally, in defending her caution regarding the use of antibiotics on her own child, Sue raises a concern for the effect the overuse of antibiotics has on other children within the community. Within this account Sue establishes her role as a parent as encompassing a wider social obligation towards others, in particular children. Together, such talk enables James and Sue to legitimate their decisions regarding child medical care use. Also evident within Sue's account is a construction of antibiotics as harmful to the child.

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**James:**

For two reasons - not only for herd immunisation, to protect the whole community and also to protect individual children.....Because of the reasons that we could still have these fatal diseases around if we didn't immunise on a global or population-based scale. And where we have epidemics of health problems is where a certain number of vaccinations aren't given to a critical number of people, and then the epidemic breaks out. I feel duty bound as a member of the public to vaccinate my children and also I would choose to do that for their own health reasons as well.

**Sue:**

Well, I'd just like to get away from this over-use on antibiotics because I also worry about the effect on the wider environment. That's one I didn't mention before, you know, increasing resistance to antibiotics in the community, so the rise of super-bugs and all of that. And this may not have any effect on my particular children but you think of future children to come and the reduction in the number of effective drugs and the ones that they do have having to be made more and more powerful.

Also evident within these accounts is that the construction of the parenting role as involving a moral obligation towards their own and other children within the community means that when a child becomes ill, the manner in which the ill child is cared for, and decisions regarding disease prevention - such as the adoption of childhood immunisation - are often constructed as moral issues for these parents. That is, the decisions these parents make regarding child medical care use are not just decisions about dealing with child health and illness, they are also moral decisions; decisions encompassing an issue of moral responsibility that reflects upon them as parents.

Further to constructing the parenting role as involving a moral obligation, parents also construct an ideal of a good parent. Central to this construction is the extent to which a parent fulfils the moral obligations that are defined within the parenting role. This includes, for example, ensuring that the child receives the best medical care possible when needed. This construction is evident in the following quote from Angela, when she describes herself as a bad mother for not taking her ill child to the doctor sooner. In this account, Angela not only presents herself as a bad parent but she also establishes an idea of a good parent and what a good parent would do, that is, put the ill child first.

**Angela:**

I think that example where I said I didn't take them over the weekend because I didn't want to go to the after-hours doctor. Part of that was my husband was away it was going to be extra hassle. I knew I was going to have to wait forever, and I'd have to drag both children along with me, and I've had some really unsympathetic doctors and I thought I don't need that. I had this call from the crèche one day and they had me screaming up there to get Sarah and they were really worried about her, and I rushed off to the doctor with her, I burst into tears in his surgery, and it was constipation and she wasn't in danger at all, but I was thinking "bad mother, bad mother!"

This concept of the good parent is similar to that of the "good mother" that appears in other research into child medical care use. In particular, within their study of the role of the chemist in primary health care for children with minor complaints, Cunningham-Burley and Maclean (1987, p. 375) found that underlying parents attitudes was an ideal notion of a good mother that consisted of "putting the health and well-being of one's children first". Further,

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it was found that responding actively and providing relief for an ill child often in the form of medicine, even when the symptoms were only minor, enabled mothers to feel that they were good mothers. Mason (1994, p. 83) found Irish mothers to perceive weight gains and “frills and flounces on clothing and prams” as signs of good mothering. Keane et al. (1993, p. 6) also found that parents describe a good mother as one that “takes care of her child, buys for it, ensures that the child has all the shots, takes the child to all the doctors’ appointments, registers him in school on time, makes sure he attends school, keeps him away from the bad crowd, attends church, gives him chores...bad mothers were described as mothers who play favourites and don’t clothe the child, but they’ll clothe their man.”

In addition to these constructions the parenting role is constructed also as involving a number of elements that are an innate part of being a parent, and others that are learnt “on the job”. In particular, the parenting role is often characterised by these parents as involving an innate drive to protect the child, instinct or intuition, nurturance, and an intimate knowledge of the child that is slowly developed. These characterisations of the parenting role are evident in the following quotes from Michelle, Penny, and Tania. Firstly, Michelle refers to her instinct to explain how she recognises when her child is not well. Secondly, Penny talks about a biological drive to protect her child. Finally, Tania talks about the process of learning to distinguish whether her child is showing signs of illness or not.

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**Michelle:**

But I found very quickly that your instinct's usually correct. If you think a child is not well, they usually are not well.

**Penny:**

...and I think that's partly a, you know, a biological thing that you are very, very protective of a new baby.....you know it's a very fierce protection for their well-being.

**Tania:**

...babies do cry a lot. But you learn to know what is normal for your baby and what is not. And so, and it takes a while to do that.

In brief, apparent within parents' accounts is that in constructing their child medical care use, parents draw on various constructions of the parenting role. In particular, the nature of parenting is constructed as involving a moral obligation towards the child. In relation to this, parents also construct an ideal of a good parent. The nature of parenting is also constructed as involving the possession and use of certain skills, that are both an innate part of being a parent and that are learnt on the job, that enable parents to fulfil their parental obligation. Overall, what is reflected in these accounts is the predominance of the parenting role in relation to child medical care use within parents' accounts and how this results in the construction of child medical care use as a moral and social issue for these parents.

### CONSTRUCTING THE MEDICAL PROFESSION

Another frequent focus of talk from these parents regarding child medical care use is the medical profession and parents' experiences and relationships with health professionals. Parents often talk of health professionals as demonstrating expertise in diagnosing and treating childhood illness, and emphasise the degree of reliance on, and trust they have in, the medical profession. Within such talk these parents generally construct the medical profession as trustworthy, having privileged knowledge, and as the authority regarding issues surrounding health, illness, and the body. Such a construction is evident in the quote below from James. In this quote, James describes his GP as a knowledgeable and trustworthy figure. This talk functions to establish his doctor as the legitimate authority and, in doing so, enables James to legitimate his reliance upon, and compliance with advice given by, health professionals. Additionally, Eunice talks about her decision to immunise her children despite the risks as involving a sense of faith and trust in the medical profession, particularly with regard to their integrity and what they endorse. Again, such talk functions to establish the medical profession as the legitimate authority regarding child health and in doing so legitimates Eunice's decision regarding immunisation.

**James:**

I guess we've got a really good relationship with our GP and I think the fact that under 6 child care is free, then we know that we can get sound advice from someone we trust. And if required, he will examine our child at the time,

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and on the basis of his examination and his knowledge and the trust we have in him, we believe he is probably the best person to make decisions about treatment.

**Eunice:**

Um, just because to me there seemed to be adequate justification to do so, I suppose. Um, and the risk that you take in them reacting badly is, appears to be, really low. And I considered the risk of them catching those things to be too high to not do it, I suppose. I don't know if that's conservative or not, but that's the recommended way to do it and I have enough faith in the system for them to be telling us the truth.

But this construction of the medical profession as trustworthy, knowledgeable, and the authority on issues surrounding health and illness does not mean that parents are not critical of the medical profession. Rather, these parents also talk about the medical profession as having limitations in their knowledge and ability. Further, the scientific knowledge upon which the health profession and conventional medicine are based is also talked about as limited. Talk from these parents does not only exemplify health professionals' accurately diagnosing and treating illness and the success of the medical profession and scientific knowledge in advancing technologies for curing and preventing illness and disease. There is also talk of doctors' sometimes getting it wrong and demonstrating incompetence, and of scientific knowledge as erroneous. Quotes from Amanda and James illustrate how parents often talk of doctors as sometimes "getting it wrong" or not knowing at all. Such talk functions to establish that health professionals are not always trustworthy, and that parents cannot always be 100% confident in the advice and treatment received from the

medical profession. Further, such talk functions to construct parents as critical consumers of child health care, both aware and accepting of the medical profession as imperfect. Altogether, within their accounts parents are critical of the medical profession, yet continue to rely and depend upon them for treatment and advice.

**Amanda:**

Things like Andy when we were in Taupo and I took him to a GP in Taupo and he said, "Oh it's definitely scabies." He gave me the stuff for it and I don't know whether we used it or not. I think I wasn't sure how to use it and I rang the nurse when we got there. She said, "Are you sure it's scabies?" and I said, "I don't know".and she said, "Come along and I'll have a look." And she said, "That's not scabies!" and that made me a bit nervous about GPs. I thought you can't sort of trust them.

**James:**

In Geoff's case, recently - when he had ulcery things on his tongue - we actually took him to, um, the after-hours doctor and he thought it was thrush, and then we went back to our own doctor because we weren't convinced that that's what it was, and he gave us another diagnosis.

**James:**

Most of the time if the doctor's honest, which our one is, he'll say he doesn't know anyway. But he'll say, "Listen, you know this could be this, or this, and I don't really know which it is - but I don't think it's serious, just keep an eye on it." And he looks in all the right orifices and ears and throat to make sure there's none of the common childhood ailments that we're trying to rule out really, and once he's done that he says, "Well, I can't find anything obvious, it's probably a viral infection, we won't worry about it"....But, um, ah, we recognise that there are a lot of childhood illnesses and a lot of them are for no reason, and - as I said - the doctor sometimes doesn't know, so we do

recognise that, and for that reason we don't sort of whip them in there at the first signs of a problem, but rather sit back. Wait. See how things pan out.

Further, within their accounts parents distinguish between “good doctors” and “bad doctors”. Within an acceptance of the medical profession as imperfect good doctors are presented variously; among other things, as those doctors that are generally caring, approachable, who listen to the child and the parent, and, in particular, someone with whom the parent has a good relationship. Conversely, bad doctors are presented as the opposite of this, in a negative manner, as self-interested, unsympathetic, and condescending. An example of this distinction between good doctors and bad doctors is evident in the following quote from Sonia.

**Sonia:**

I suppose that there are good doctors out there and there are bad doctors. And we got our doctor when we first moved to Palmerston North. My husband... the doctor was just around the corner, my husband needed to see a doctor. So we got him that way just because he was closest to our house. Um, but I know there are a lot of people who're afraid of changing their doctors if they have a bad one. What will my doctor think of me? And I think well, if he's bad anyway, who cares! Um, just find a doctor that you really like so, ah, um, if you've got a good doctor and you feel like you're being supported and your doctor doesn't make you feel like an idiot, cool. And our doctor's just like that. Not once has he ever made me think, you know, you've brought this kid in again! And, yeah, even when he's flat out he's still really pleasant.

In relation to the critical construction of the medical profession, these parents generally do not construct health professionals as having total control over

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matters concerning their child's health and well-being. Although parents construct health professionals as people upon whom they are dependent or reliant for expertise, they also construct their relationship with health professionals as one in which they, as parents, exercise a degree of autonomy and control. Parents talk about making demands, questioning medical judgments, possessing personal expertise of the child, and making their own decisions concerning child medical care. Such talk functions to create a symmetry in expertise, control, and power between parents and health professionals. In this respect, health professionals are constructed as partners in the health management of children within a partnership where parents play an active, as opposed to a passive, role and where parents make a substantial contribution. This construction of the relationship between parents and health professionals is apparent in the following quotes from Lucy, Sue, and Tania. Firstly, Lucy talks about instructing her doctor that her child not be given any medicines, thus depicting herself as exercising a degree of control over what treatment her child receives. Secondly, Sue talks about her own relationship with her doctor, highlighting her and her husband's active involvement in their child's health and illness and the degree of equal standing and partnership between them and the doctor. Finally, Tania talks about her relationship with her doctor, highlighting the expertise, in the form of intimate knowledge of her child, that she contributes to the relationship. In doing so, Tania emphasises the symmetry in expertise that exists between herself and the doctor.

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**Lucy:**

Last week with their cough I wasn't sure whether it had moved to a chest infection – whether we needed something or not. The doctor said, "He should be all right," I said, "Fine, I don't want drugs," then you know - we'll carry on.

**Sue:**

Yes, we're both academics so we probably are fairly typical in that we read a lot. Like they had chicken-pox recently and we were on the Internet finding out things about it and medicines. That sort of thing. I think you could say we keep our doctor on his toes. I think he relishes the challenge of it. He likes a good debate and we have a dialogue and we see ourselves as partners in the health management of our children, and we respect his training..in.. conventional medicine. And I would like to think that he respects our views, although he may think they are often misguided.

**Tania:**

...you get to read signs that aren't very overt and so the doctor might not be sure of that because they don't know your child. Um but after a while they come to trust your instincts, if that's what they are. And you know they're actually prepared to treat a child before there are actually enough symptoms in their minds to say, "Yes the child needs antibiotics"...He's always been very accepting of me arriving saying I know what's wrong....he's very good with just accepting my advice.

In summary, these parents generally construct the medical profession as trustworthy, having privileged knowledge, and as the authority on matters surrounding health, illness, and the body. However, parents also construct the medical profession as limited in their knowledge and ability and distinguish between good doctors and bad doctors. Further, parents construct their relationship with health professionals as that of a partnership that is characterised by a symmetry in expertise, control, and power. Overall, these

parents construct the medical profession in different, complex, and contrasting ways that reflect a critical perspective of the medical profession.

### CONSTRUCTING CHILDHOOD ILLNESS AND DISEASE

Within their accounts these parents describe in detail how they come to recognise when their child is ill. Parents talk about, in addition to using symptom lists developed from information given by medical professionals, developing over time through the unique parent-child relationship a sense of what is normal behaviour or appearance for their child. This includes things such as sleeping patterns, eating behaviour, the way a child smells, and temperament. Within their accounts parents construct illness as a disruption to - or deviation from - this normal state. This may include a deviation that is as subtle as a change in the pitch or tone of a child's cry. With regard to this construction, the recognition of illness is specific to each particular child and is not static but continuously changing as the parent "gets to know" the child. The following quote from Angela provides an example of this construction of childhood illness. When talking about her child being ill, Angela draws on the concept of her child not being himself; himself being the normal state of this child. Such talk not only constructs illness as a deviation from normality, it also enables Angela to establish a significant role for herself, as a parent, in recognising illness in her child.

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**Angela:**

Sometimes they just creep up on you and all of a sudden you realise that for a couple of days they've not really been themselves. But, you hadn't thought about it much, and then you might consciously realise that they're not themselves.

Similarly, Cunningham-Burley and Maclean (1987) found that mothers talk of developing a notion of what is normal for their own child and working with this concept of normality in recognising illness. This notion of normality was related to a mother's unique knowledge of the child and the child's behaviour. Later on Cunningham-Burley (1990) refers to this normality as not a static notion - "what could be taken as normal changed over time as a child developed from a baby to a toddler..the mothers also learned from experience, and changed their definitions of normality accordingly" (p. 100). Spencer (1984) also talks about the ability of parents to judge what is normal or abnormal behaviour in their child and how this is a skill, that only parents possess, in distinguishing that something is wrong.

In the present study, in relation to parental conceptualisations of the child as a biological body or entity, parental talk specifically constructs childhood illness and disease as a disruption to, or deviation from, the normal biological and psychological or emotional functioning of the child. This construction is evident when parents talk about illness or disease as a bodily malfunction or as involving physical changes, or when they refer to the ill child as grizzly or sad compared to their usual happy self. This construction is evident in the

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following quotes from Eunice, Cath, and Michelle. Firstly, Eunice talks about what signs indicate to her that her child is ill, in doing so she refers to out of the ordinary things to do with behaviour and physical things such as a temperature. Secondly, Cath and Michelle talk about knowing their child is not well when the child who is normally happy becomes emotional.

**Eunice:**

...and now we know that, um, that out of the ordinary things to do with sleep. Or out of the ordinary things to do with behaviour are a good thing. As are medical, like a temperature or, um, um, all those sorts of things.

**Cath:**

Her behaviour changed. Well, physical there's physical signs like I say I can tell by looking into her eyes. Just without her saying or doing anything. And, and the physical sign of her face being flush. But her behaviour definitely, too. She was normally bright and happy - and she wasn't. She was obviously distressed about something. Again, just that she's normally very happy.

**Michelle:**

I look at my children and think "that child's not well." You know, and you've just got these vague sort of things that you can't put your finger on. They're just acting a little bit different. A child who's normally happy might be edgy or, or, prone to bouts of tears. But you can always tell the difference between that and tired.

Childhood illness and disease are also constructed as bigger than the biological or psychological child. Parents often construct childhood illness and disease as disruptions to the social environment surrounding the ill child; they have a social impact, such as that on daily routine surrounding the family. Within their accounts this social impact is often talked about as of equal, or greater,

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concern than the disruption to the biological or psychological functioning of the child. In the quotes below, both Sally and Sue talk about deciding to take their sick children to the doctor because of the effect the ill child is having on the whole family. In doing so, Sally and Sue establish childhood illness as having a social impact and use this in providing an argument for taking the ill child to the doctor.

**Sally:**

I'd probably then would say, "Well, I want something because we're getting disturbed nights now. The child's getting disturbed nights and everyone's getting a bit tired."

**Sue:**

They have to be fairly seriously unhappy, I guess, to take them along. If we can see that it is just minor pain, if he's dribbling or putting his fingers in his mouth, we know that teeth are coming through and we wouldn't bother. But in this case it was the uncertainty and the lack of sleep. The disruption to our sleep that made us go "oh yes, help!"

These accounts not only demonstrate how childhood illness and disease are constructed by these parents, they also reflect the fact that it is not only the biological aspects of childhood illness and disease that are constructed as issues that need to be managed, rather an unhappy child or a disturbed routine or lack of sleep among family members, for example, are also constructed as problems in themselves that need to be managed. Further, the construction of childhood illness and disease as disruptions to biological and psychological or emotional functioning and the wider social environment establish that childhood illness

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and disease are more than purely biological phenomena thus extending or resisting the boundaries of the biomedical model.

When talking about childhood illness and disease parents describe these in various ways that function to construct them in two contrasting ways. To begin with, illness and disease are often described as potentially harmful or “destructive” to the child’s body, health, and general well-being. Such talk is apparent in the following quotes from Tania and Emma. Firstly, Tania talks about why she took her ill child to the doctor, and describes the long-term consequences of an ear infection as part of her reason. Secondly, Emma talks about deciding to immunise her children partly because of the effects of whooping cough, describing these as including “wrecked lungs” and social scarring. Such talk establishes certain illness and disease as serious and in need of medical treatment and prevention, and in doing so legitimises parents’ decisions regarding child medical care use.

**Tania:**

Um, and that, it’s the sort of thing that in my experience needs medical intervention to get rid of it. And because it has potential long-term consequences I don’t want to just sit it out and see what happens. I want it treated..... So that I’m not going to end up with a child that has got a hearing deficit or something.

**Emma:**

My sister had whooping cough as a child. Wrecked her lungs. And, just she was probably always a frailer person. Um, but it had a socially scarring effect on her...So, quite apart from the physical consequences she always got coughs

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and colds and flu. And it always went down and gave her this awful cough from then on...But she also I think was scarred socially from that experience.

In contrast to this construction, parents often talk of illness and disease as beneficial processes - things that do not affect the health and well-being of the child, and "passing" processes. Such talk constructs childhood illness and disease as "normal", "natural" processes that are not in need of medical treatment or prevention. Despite presenting these various descriptions of childhood illness and disease separately here, these ideas are interrelated in that an illness that is described as a "passing thing" may also be described as "beneficial".

Firstly, parents often describe illness or disease as a process that serves a beneficial purpose for the child's body and health. In particular, such childhood illness and disease are presented as facilitating the development of the child's immune system. Such talk is evident in the following quotes from Sue and Cath. Firstly, Sue talks about why she often chooses not to take her ill child to the doctor. In doing so she talks about an aversion to using antibiotics due to the belief that they interfere with the process of building up a resistance, implying that in this way they may be detrimental to child health. Following this, Cath talks about deciding not to immunise her child - partly because of a belief that contracting a childhood disease, such as measles, serves as a way for her child to develop lifetime immunity. What is also evident in these quotes is how parental ideas surrounding the child's developing body, in particular the

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immune system, relate to their ideas regarding childhood illness and disease. Further, there is also evidence within these accounts of the construction of the child as 'strong' and a biological entity.

**Sue:**

That's one I didn't mention before, you know, increasing resistance to antibiotics in the community. So the rise of super-bugs and all of that, and this may not have any effect on my particular children but you think of future children to come and the reduction in the number of effective drugs. And the ones that they do have having to be made more and more powerful. And it worries me that it's like interfering with the natural order. I'd rather that they get through it on their own and that their bodies develop their own resistance.

**Cath:**

...like say measles, if she gets it, she gets it...I don't mind if she does get it. At least I know then that she does have lifetime immunity...I think that too much has been made out of kids' getting measles. So I wouldn't try and avoid her having contact with something I didn't think that was really serious.

Parents also often describe childhood illness as something that does not necessarily affect the overall health and well-being of the child. That is, for a child to be suffering from a particular illness does not necessarily mean that the child is ill or unhealthy. For example, Eunice talks about not taking her child to the doctor, despite the fact that she was vomiting, because she (Eunice) was not worried about the child's health.

**Eunice:**

Um, 'cause they're at crèche there's like an exclusion thing - like, if they vomit you've got a 24-hour exclusion which is a real pain. So I would never go to the doctor just for vomiting. So I have stayed at home with Fleur, who was

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completely healthy, but she vomited the night before and has to stay away from crèche. Um, in my judgement there is nothing wrong with her...There's nothing else wrong with them. You know a child sort of vomiting can be just a one-off thing.... You give Fleur pineapple and she vomits. So you know it's not a, it's not a, it's not an... I'm not worried about them health-wise necessarily.

Childhood illness is also often described as a passing process, that is, an illness or disease that will eventually disappear over a period of time without treatment. Such illness is often referred to as a passing thing, something that will "run its course" or "resolve itself". Such talk is evident, for example, when Caryl and Megan discuss illness episodes when they chose not to take their ill children to the doctor. In doing so, both Caryl and Megan describe these particular illnesses as something that "will resolve itself within a couple of days" or something that will "run its course".

**Caryl:**

I mean if they have colds I would not go to the doctor straight away. Rarely would I go to the doctor straight away with a cold because I know that, generally, it will go away. But it'll resolve itself within a couple of days. And if it doesn't, then I go.

**Megan:**

I just think, you know, let it run its course and give them, you know, something for the pain and fever.

In general, such talk constructs childhood illness and disease as normal, natural processes. They are familiar or common ailments or something that is

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considered a part of the life stage of childhood; they are an expected and accepted part of childhood and daily life. This functions to establish childhood illnesses and diseases as not in need of any medical treatment or prevention, and even suggests that to do so may be unhelpful or even detrimental to the child's health. Further, such talk works to legitimise parents' decisions regarding child medical care use or non-use.

Similarly, Cunningham Burley (1990) and Cunningham Burley and Maclean (1987) found mothers to refer to some illnesses as normal and even healthy. These researchers found that a normal illness is one that the child was anticipated to experience, during which s/he is able to carry on as normal without the disturbances or disruptions that are often associated with illness, and that did not affect the general health and well-being of the child.

In summary, within their accounts parents construct childhood illness and disease as disruptions to, or deviations from, the normal state of the child; encompassing both their biological and psychological or emotional functioning. Childhood illness and disease are also constructed more widely as disruptions to the social environment surrounding the ill child. In addition to these rather general constructions, these parents described childhood illness and disease in terms that constructed them in diverse ways; as either serious and in need of treatment and prevention, and as normal, natural processes not in need of treatment and prevention. Altogether, these constructions enable parents to legitimate and defend their decisions and actions regarding child medical care

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use. Overall, what is demonstrated here is that parents' accounts reflect a diverse range of conceptualisations of childhood illness and disease.

### CONSTRUCTING MEDICINES

Within parental talk, medicines are generally referred to as a means of restoring the body or the child to a normal state. However, this does not mean that these parents are not critical of medicines and their use. Although parents often emphasise a reliance upon - or necessity for - medicines, they also express a caution or reluctance regarding their use. With regard to using medicines, these parents primarily talk about adopting two different forms of medicines to prevent, treat, and relieve childhood illness and disease; conventional medicines and alternative medicines. Within such talk conventional and alternative medicines are constructed in different, complex, and contrasting ways, along various dimensions that reflect this critical approach to medicines and their use.

Examples of such talk are evident in the following quotes from Annette, Sue, and Amanda. Firstly, Annette draws on a description of alternative medicines as a more natural form of medication and uses a comparison of conventional medicines to defend her decision to use alternative medicines. This is also achieved by Annette's describing alternative medicines as "not as strong", "it's a bit more subtle" and as "working with the body" in a noninvasive manner.

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Further, Sue draws on a concern for - and description of - conventional medicines as “unnatural” and “strong”, implying that alternative medicines are the opposite of this, to defend her use of alternative medicines and decision not to take the child to the doctor. Finally, Amanda talks of her search for a strong treatment for her child’s rash. Altogether, such talk establishes conventional medicines along dimensions of naturalness and strength as strong and unnatural.

**Annette:**

[talking about alternative medicines] For me it's comforting to know that it's not a derived medicine in a laboratory. You know it's not as strong. It's a bit more subtle. It gives your body a chance to work with it, and stuff.

**Sue:**

Well, with eczema for example. With the youngest one we have bought a variety of different natural creams ourselves from health food shops or Pharmacies and tried those. Rather than using the steroid creams that the doctors prescribe. Because for those same reasons as I mentioned earlier, not liking anything unnatural or too strong by way of medicines....Yes, I definitely try to avoid the steroid cream we've got for the baby's excema, but sometimes when it flares up it can't be avoided and we think “oh we have to use that creme again tonight.” I just use it once every 2 weeks.

**Amanda:**

..when it was her christening she had a rash on her chin and I sort of said, “Give me the strongest stuff you're allowed to give,” to get rid of the rash.

Related to the construction of alternative and conventional medicines as varying along a dimension of “naturalness” and “strength” are parental

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constructions of these medicines as varying in degrees of harmfulness. With regard to alternative medicines, parents construct these medicines as harmless to the child's body. Evidence of this construction is provided in quotes from both Cath and Emma in which they defend their use of alternative medicines by drawing on, and describing, the use of such medicines as "not doing the child any harm". Such talk not only establishes alternative medicines as harmless, it also implies that the use of conventional medicines involves risk.

**Cath:**

Perhaps homeopathic remedies will cure here. Then why not give it a go? It can't do her any harm. There's nothing to lose.

**Emma:**

And he took these drops. And she told me what was in them: there was garlic, various herbs and things that I knew about. And so I thought, "Well, it's not going to hurt him."

Alternatively, parents construct conventional medicines as potentially harmful to the child's body, both directly and indirectly. This construction is evident in the quotes from Sue and Gill. Firstly, Sue defends her caution regarding taking her ill child to the doctor by drawing on a concern for, and describing, the long-term effects conventional medicines can have upon the child's body and immune system. Secondly, Gill defends her caution regarding taking her ill child to the doctor by drawing on a concern for and describing the risk that conventional medicines impose upon the child's body in terms of developing a tolerance or immunity to their effectiveness. Such talk functions to establish

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conventional medicines as potentially harmful to the child's body and the use of conventional medicines as involving risk to the child.

**Sue:**

I hate them being on antibiotics. Both my husband and I are quite pro-natural medicine, and both of these two children unfortunately have had a lot of antibiotics during their short lives. Despite me always saying to the doctor "I don't want them to have this unless it's essential," and almost always he says "Well, it's essential".....I'm very concerned about the long-term effects of children having too many antibiotics, effects on their teeth and teeth that might not have come through yet, and effects on the immune system.

**Gill:**

I just, from things I've read, I, I think that maybe you become immune to, there's only so many sorts of antibiotics as such. There's not that many at all. And your body does become more immune to them. I don't know if it's just I've only read the biased. But, so, rather, there's gonna be worse things as they get older presumably. So if they have to be on antibiotics I'd rather they - if they're going to take them - they took them. When they do take them they get the full effect of them. They haven't, you know, had a bottle for every little cold when they were a baby.

This construction of conventional medicines as harmful also extends to encompass the potential harm to community members. The harmfulness of conventional medicines is constructed as wide-ranging, and not relating either solely or directly to the child's body. In the following quote, Sue justifies her decisions not to take an ill child to a doctor by drawing on a concern for - and describing - the effects of these medicines on the wider community. Such talk establishes conventional medicines as harmful to the community.

**Sue:**

Well, I'd just like to get away from this over-use on antibiotics, because I also worry about the effect on the wider environment. That's one I didn't mention before. You know, increasing resistance to antibiotics in the community. So the rise of super-bugs and all of that, and this may not have any effect on my particular children, but you think of future children to come and the reduction in the number of effective drugs, and the ones that they do have having to be made more and more powerful, and it worries me that it's like interfering with the natural order. I'd rather that they get through it on their own and that their bodies develop their own resistance. But the GP would disagree with me on that, and say that it's got no long-term effects on them and not to worry. You should treat each infection on its own. It's just that they hate having this and I hate giving it to them because I feel torn, I'm in two minds about it. I don't 100% believe that it's actually going to do them any good anyway, so I don't like giving it to them.....I hate them being on antibiotics. Both my husband and I are quite pro natural medicine, and both of these two children unfortunately have had a lot of antibiotics during their short lives. Despite me always saying to the doctor "I don't want them to have this unless it's essential," and almost always he says, "Well it's essential." So that is in our minds when we decide well, we won't go today - we'll wait till tomorrow to make an appointment.....I'm very concerned about the long-term effects of children having too many antibiotics. Effects on their teeth and teeth that might not have come through yet, and effects on the immune system.

In contrast to these rather negative constructions, conventional medicines are also constructed in a positive manner as an effective "quick fix" solution. Parents often talk of conventional medicines as offering an effective solution that enables a child to quickly recover from an illness or feel a sense of relief. The following quotes from Tania and Debbie provide illustrations of such talk. Firstly, Tania describes the quick work of antibiotics on returning her ill child to good health. Secondly, Debbie talks about choosing to use conventional

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medicines in situations when she needs to get her child back to health quickly. Such talk establishes conventional medicines as quick fix solutions.

**Tania:**

Course I was amazed how quickly antibiotics work. You know, you'd have a very, very distressed child who wouldn't eat, who wouldn't settle, who was crying and obviously, you know, upset. Give him antibiotics and within about 3 or 4 hours he was almost back to normal, really.

**Debbie:**

Now we're both working really hard, we both need to be at work, it's probably just to get him healthier quicker, so we can get back to work.

In comparison to conventional medicines, parents generally construct alternative medicines as taking effect over some time as opposed to providing a quick solution to illness, and describe their efficacy as less certain; often talking about the use of alternative medicines as involving several treatments. This construction, along with the construction of conventional medicines as a quick fix solution, is evident in the following quote where Amanda defends her occasional use of conventional medicines, within a discussion on her frequent use of alternative medicines, by referring to alternative medicines - in comparison to conventional medicines - as slow working.

**Amanda:**

Um, well in an emergency situation. Well, if a child has breathing difficulties I'll bring him to the GP. I don't think anything natural is going to fix him that fast. Um, if my child cut itself I would definitely get them stitched up.

Similarly to these findings, previous research (Zaman, Zeitlyn, Chakraborty, de Francisco, & Yunus, 1997) into child medical care use has found that, among practitioners and parents, it was thought that homeopathic medicines were milder and less “heating” than antibiotics which may have side-effects, and so the former were particularly suitable for children. It was also found that practitioners and many parents reported that homeopathic medicines worked more slowly than did conventional medicines.

In contrast to the construction of conventional medicines as offering an effective solution or cure, at times they are also described in a different manner - when contrasted with alternative medicines - as providing merely a treatment-oriented solution, and not necessarily an effective one. Further, alternative medicines are often described as providing a cure for illness and disease. Alternative medicines were variously talked about as getting to the “root of the problem”, “fixing the underlying cause”, or “getting to the bottom of it”. Conversely, conventional medicines were often talked about as not getting to this underlying cause, but merely treating the immediate symptoms. Such talk functions to construct alternative medicines as providing a cure-oriented approach and conventional medicines as providing a treatment-oriented approach to dealing with childhood illness. These constructions are apparent within parental talk regarding the use of alternative medicines as a last resort, after having tried conventional medicines and having these fail, or to complement conventional medicines. In this sense, alternative medicines are constructed as “filling the gaps” evident within treatment with conventional

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medicines. Conversations with both Amanda and Cath regarding their choice of medicines during particular illness episodes provide illustrations of these constructions. Both Amanda and Cath talk about approaching alternative health professionals in an attempt to get to the bottom of the problem of their child's illness or to fix the underlying cause. In these accounts Amanda and Cath establish alternative medicines as providing a possible cure to illness while conventional medicines do not.

**Amanda:**

And the reason I went to the natural people was I thought, "Let's get to the bottom of this problem rather than just treating him."

**Cath:**

So I looked at an alternative and that's why I looked at the chiropractor as well. If it's got to the stage where antibiotics are not clearly working, perhaps something...perhaps homeopathic remedies will cure here. Then why not give it a go. It can't do her any harm. There's nothing to lose..... Antibiotics work in the short term. They do knock the problem on the head. But they don't fix the underlying cause of it.....And unfortunately conventional medicine tends to treat it and I was hoping homeopathic might prevent it rather than fix it.

These accounts not only demonstrate how parental talk constructs conventional and alternative medicines in multiple and contrasting ways, they also reflect how medicines are often understood through their effects on the child's body and that there is often a tension between the positive and negative aspects of medicines and their use. These accounts also illustrate that these constructions of conventional and alternative medicines not only enable parents to legitimate

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or defend their decisions regarding the use or non-use of alternative or conventional medicines, but also their decisions regarding going to the doctor. Additionally, they illustrate how the same construction such as that of conventional medicines as strong can enable parents to defend decisions both for and against the use of conventional medicines.

Previous research into child medical care use (Zaman et al., 1997, p. 104) found parents to use a combination of allopathic and alternative medicines and that the 'belief in one system need not preclude faith in other types of treatment'. Similarly, in this study - although parents construct alternative and conventional medicines in contrasting ways - for some parents this does not necessarily mean the total abandonment of one for the other. Rather, these parents present themselves as picking and choosing between alternative and conventional medicines to meet their particular needs or desires for each particular illness episode; using either one or the other, or a combination of both conventional and alternative medicines. Within these accounts parents establish themselves as taking an eclectic approach to medicine use and as being critical and active consumers aware of, for example, the side-effects of medicines, and shopping around for the best deal. This allows for a resolution of the conflicting constructions that they report, in that one or the other can be drawn on in a particular episode of illness. Doing this not only enables parents to present themselves as caring for the child in the best way they see fit, it also enables parents to be both critical of, and reliant upon, these two different forms of medicine.

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In brief, within their talk these parents construct conventional and alternative medicines in various ways as varying along dimensions of naturalness and strength, harmfulness, speed and efficacy, and in terms of whether they provide a treatment - or cure - oriented solution. These constructions are variously drawn on by these parents to legitimate or defend their use or non-use of conventional or alternative medicines. Overall, what is reflected in these accounts is the critical approach of these parents towards medicine use.

In summary, parents' accounts surrounding child medical care use reveal that these parents actively construct children, the parenting role and the 'good parent', the medical profession and their relationships with health professionals, childhood illness and disease, and medicines, in various - often contrasting and interrelating - ways. This chapter has revealed that these constructions are woven throughout parents' accounts and often used in multiple ways to legitimate and defend parents' actions regarding child medical care use. What has also been revealed in this chapter is the complex and contradictory nature of these constructions.

The accounts presented here not only reveal the manner in which parents construct children, the medical profession, and childhood illness and disease, they also suggest that, for these parents, child medical care use is not simply about responding to symptoms of illness. Rather, child medical care use involves a number of complex issues surrounding, for example, medicine use, the child's body, and health professionals. Overall, the analysis presented here

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explicates the constructions evident within parents' accounts that are central to, and provide a backdrop or context from which we can begin to understand, how they construct their child medical care use. The following analysis, presented in two chapters, investigates and explores how these parents construct their child medical care use in terms of seeking medical treatment and prevention for childhood illness and disease from a medical practitioner or nurse.

## CHAPTER SEVEN

### CONSTRUCTING THE UTILISATION OF MEDICAL CARE: SEEKING CARE

When a child becomes ill there are a number of options a parent can take in terms of dealing with the illness; these include seeking treatment or advice from the doctor, nurse, pharmacist or alternative health professional, consulting friends or family, or caring for the ill child themselves at home with the use of over-the-counter medicines, alternative medicines, or no medicines at all. The focus of this chapter is the decision-making process surrounding seeking treatment from the doctor. The reason for this focus is that the parents in this study present their actions in terms of dealing with an ill child as involving a decision-making process that centres primarily around deciding whether to take the child to the doctor or not. Further, other pathways such as consulting friends and family are depicted as an outcome or a part of this decision-making process and issues surrounding seeking treatment from the doctor. For example, parents talk about friends and family members as serving as referral agents for going to the doctor, or parents talk about turning to alternative

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health professionals due to a concern regarding the use of conventional medicines prescribed by doctors.

Seeking treatment from the doctor is depicted by these parents as a process that begins with the recognition of childhood illness. However, illness recognition is not always presented as a simple and straightforward matter. Parents often describe episodes when they experienced difficulty in recognising illness and were unable to make sense of or rationalise possible signs or symptoms of illness in terms of their understandings of childhood illness. In times of such uncertainty parents often talk about waiting until they are sure that the child is ill and really in need of medical intervention before seeking care.

However, illness recognition does not necessarily mean that a parent will seek medical care either. Parents say that even if they know that their child is ill they may still delay seeking care or even refrain from doing so altogether, often resorting to other ways of dealing with the ill child - for example, administering over-the-counter medicines at home or using alternative medicines. So why is it that parents are often reluctant to seek medical care in times of both uncertainty and certainty of childhood illness?

Within their accounts these parents depict treatment-seeking as involving a decision-making process comprising facing and negotiating various issues and concerns characterised by tension, conflict, and dilemma. This tension, conflict, and dilemma revolve around issues and concerns regarding appropriate

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medical care use, the risk of medicines, practical barriers to seeking care, and competing demands and priorities. I will now focus on explicating, in turn, these issues and concerns.

### DOING THE “RIGHT” THING

Within their accounts these parents frequently discuss the particular circumstances under which they would take a child to the doctor. Woven throughout these accounts are ideas regarding the appropriate or “right” thing to do in terms of seeking medical care: responsible parents should take a child to the doctor when he or she is seriously ill and in need of medical intervention and, at the same time, should not bother the doctor when they are either unsure if the child is ill or for a minor illness, such as a cold that does not need professional medical intervention. At one extreme, failing to take a seriously ill child to the doctor is perceived as placing the child at risk yet, at the other extreme, seeking medical care for a child who may not be ill or is merely suffering from a minor illness is often perceived as unnecessarily bothering the doctor. These ideas of appropriate treatment-seeking are presented as originating from previous interactions, experiences, and advice received from doctors. Further, they are presented as socially shared among, and reinforced by, other parents and social networks. Altogether, treatment-seeking is depicted as shaped by a professionally and socially legitimated framework.

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Apparent within these accounts is that these defined boundaries of appropriate medical care use are intricately tied into parental constructions of what it is to be a good parent and what a good parent would do. The distinction between good and bad treatment-seeking slips into a distinction between being a good or bad parent. Also apparent within these accounts are parental constructions of doctors as the legitimate authorities and parents placing doctors within a position where they can either undermine their status as a good parent or affirm it.

With regard to these boundaries of appropriate care-seeking, when it comes to seeking help from a doctor a concern for utilising these services appropriately becomes a source of tension. This tension significantly impacts upon parents' treatment-seeking when either seeking care for the first time or returning to the doctor for the same illness episode. Such talk is apparent in the following quotes from Lucy, Jo, and Caryl. Firstly, Lucy talks about not taking her children to the doctor when she merely suspects they may be ill because she does not want her doctor to think she is stupid or neurotic. Secondly, Jo talks about delaying taking her ill child to the doctor due to a concern with wasting the doctor's time and looking like a fool or a neurotic mother. In doing so, Jo describes herself as caught in a dilemma between possibly wasting the doctor's time and a concern for her child's health. Finally, Caryl talks about her decision to return to the doctor during the same illness episode as a tough one due to the concern that she will be perceived by the doctor as a neurotic parent.

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**Lucy:**

I don't want to pester the doctor though. I don't want him to think I'm a stupid neurotic lady. But now having two children I think I've learnt from the first. I certainly was there more with the older one than I am with the younger one. I think it is a learning process and you learn a bit as you go along.

**Interviewer:**

So what were the reasons why you waited?

**Jo:**

I guess because we'd been so many times before and they have just done nothing. And you think, "Oh, you feel a fool," and you think they're gonna say again, "No he's okay, take him home"...and so you go up and they say, "No, this is fine." You think you've wasted their time. And so when the same things happen again you think, "No, I won't go this time." And then, of course, those little doubts creep in. You'd never forgive yourself if you made the wrong choice. One of the harder things about bringing up children I think...perhaps it's been the odd time we've gone and they've done nothing. They've said, "No he's perfectly all right at home." And you get the feeling they think you're a neurotic mother and you feel embarrassed. But then I don't think I regret it because I think well, at least you come home and it's peace of mind. But you do feel a little bit silly.

**Caryl:**

I took her to the um, I did take her to the after-hours...she had a very sore throat and I can't remember whether it was a fever or not - she was just, you know, very unwell. Limp is yeah, probably - well, she was getting that way. Took her there and they looked at her and they said, "Well, there's nothing we can do for her, she's just got a virus." So I trotted away. And then she slept that night probably very fitfully as she often did. And the next morning I realised that she probably wasn't getting any better. And she felt really limp...really limp in my arms, really hot, just, and she was dribbling...and I thought, "This is odd, you know." And I thought, you know, I must be going crazy here. So I decided, and the decision to take a child back to the doctor when you've just taken them is quite a hard one to make. You think...you feel

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like you're a neurotic mother. You do, you do, you do. Um, but I did and the doctor said, "I'm really glad I've seen you." "She's got quinsy," which is this real infected throat.

Evident within these accounts is that this tension regarding appropriate care-seeking often leads parents to a dilemma between the risk of being perceived by the doctor as neurotic and as wasting their time and a concern for the health of the child. This tension and dilemma are dealt with, or resolved, in various ways with parents often consulting a nurse, pharmacist, books, or friends and family to act as referral agents for the doctor. Parents also attempt to deal with this tension or dilemma by taking the child directly to the doctor and risking being perceived as neurotic. Alternatively, parents may attempt to find a balance by delaying treatment-seeking and caring for the child at home until they are sure that they need professional treatment. Interestingly, waiting or delaying going to the doctor and initially treating the child at home is presented within these accounts as an important strategy. Doing so allows parents to monitor the illness signs and symptoms and better assess what action to take, that is, whether to seek professional care or not. Further, this tension and dilemma regarding appropriate treatment-seeking are presented as an ongoing problem for these parents. It arises when first considering whether to take an ill child to the doctor and when considering returning to the doctor, as evident in the quote from Caryl. This demonstrates not only that these issues are not simply resolved once the parent has been to the doctor, but also that treatment-seeking occurs along a pathway to care that begins with the recognition of childhood illness and proceeds through to treatment-seeking

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and, after treatment has been sought, until the child has returned to good health.

These findings are similar to those of previous research. For example, a number of researchers (e.g., Colucciello & Woelfel, 1998; Cornford et al., 1993; Cunningham-Burley & Irvine, 1987; May, 1992; Spencer, 1984; Tupasi et al., 1989) have identified the fact that parents often seek help from a health professional only when the health problem the child is suffering from is perceived as serious. Further, such research has found that the majority of mothers try over the counter medicines before taking their child to the doctor and that parents often consulted others, for example, friends and family, for medical advice.

Similarly, Cunningham-Burley and Maclean (1987a) and Spencer (1984) found that mothers relied considerably upon self-care, often wanting to see how things developed - consulting the chemist when a child became ill, and resorting to the doctor only when there was no evidence of improvement in the child's health. In relation to this they found, consistent with the findings in this study, that when the child was suffering from a minor illness the doctor was not always considered the appropriate person to consult. They found also that underlying this was a concern not to bother the doctor with trivial conditions. Further, Cunningham-Burley and Maclean (1987a, p. 256) found that:

How the mothers see themselves and see their relationship with their doctor was captured in the following two phrases: not bothering the

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doctor, and not wanting to seem stupid. The mothers were caught in a dilemma of wanting to be seen as competent, in other words to be able to care for their children themselves, yet also wanting to be sure that their child was not seriously ill, thus needing the reassurance of their GP. They did not want to go to the doctor with trivial illness, but did not want to neglect a serious or more acute condition. This dilemma of the mothers is not so different from that facing a general practitioner. However the mothers felt that they should not bother the doctor or waste his/her time. If they went and nothing was wrong, this could, if not handled sensitively by the GP, result in the mother's feeling inadequate.

Within these accounts it seems that parents are trying to act according to the professionally legitimated boundaries of appropriate treatment-seeking and do the right thing, and with a conflicting concern for the child. Either way in which parents deal with this issue it is worked through in a manner that enables parents to negotiate a position for themselves as good parents - as acting according to their moral obligations towards the child. This is aided by the use of contradictory constructions of the child as strong and fragile and constructions of illness as serious and a normal, natural process that is variously drawn on to legitimate or defend parents actions by establishing treatment-seeking as either necessary or unnecessary.

In general, throughout parents' accounts is evidence that medical thought has a predominant impact or influence upon parents. For example, within their

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accounts parents frequently draw on biomedical terminology, biomedical concepts and explanations, and often frame medical care use within a biomedical framework of understanding. The influence of medical thought is also reflected in parents' constructions of the child, medicines, doctors, and illness and disease.

In relation to the predominant presence of medical thought within parents' accounts is the fact that the use of child medical care in general, for treatment and prevention, takes place within the context of the phenomenon of medicalisation. Medicalisation is defined as the process in which everyday phenomena such as childhood illness and child health, childbirth, or breastfeeding are transferred into medical problems therefore requiring medical expertise and intervention. Medical professionals, such as doctors and Plunket nurses, and medical intervention in the form of medicines become necessary, relevant, and taken for granted. This is accompanied by a removal of child health and illness management from the lay sphere.

Literature and research conducted within New Zealand (e.g., Beasley, 1996, 1999) demonstrate how, within New Zealand society, breastfeeding and menopause are medicalised and how lay people often resist such medicalisation. With relevance to the present study, research has demonstrated how issues of child health and illness have not escaped such medicalisation. In a study investigating how measles vaccination campaigns have been promoted and resisted Dew (1995) argues how childhood disease, such as measles,

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becomes medicalised within New Zealand society through the major institutions of the medical profession and the media. Dew argues that the medicalisation of a childhood disease, such as measles, converts a mild and easily treatable disease into a problem that needs to be dealt with by technical means, out of the sphere of the parent. Accompanying this is the transformation of a childhood disease as a social problem into a medical problem. It is within the broader context of this phenomenon of medicalisation that child medical care use takes place. Within this study there is evidence of acceptance, resistance and, at times, of parents' shifting between an acceptance and resistance of the medicalisation of child health, illness, and disease.

Within their accounts surrounding treatment-seeking parents often draw on ideas of childhood illness as a biological malfunction that can and, at times, should be repaired with medical intervention. Within these accounts attention is often given to a reliance or dependence upon medical intervention to provide a solution. Such talk reflects an acceptance of childhood illness as a medical concern and in doing so focuses attention on the need for parents to utilise medical intervention.

In summary, throughout the process of care-seeking, appropriate medical care use is a source of tension and dilemma for these parents that impacts upon their care-seeking behaviour. Overall, parents generally present their help-seeking as occurring within a socially and, in particular, a professionally legitimated framework. In relation to this framework, seeking treatment from a doctor is

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conceptualised as a social process not only in the sense that social networks are referred to, guiding or influencing parents' help-seeking, but also in the sense that help-seeking is shaped by socially shared ideas of what is right or wrong help-seeking behaviour. This establishes treatment-seeking not as a simple matter of individual choice, rather it is a social process that takes place within a context of socially shared ideas regarding appropriate treatment-seeking that are linked to ideas of what it is to be a good parent and what a good parent would do. As a result, treatment-seeking is depicted as immersed within a social context.

### **LIMITING RISK**

In addition to this focus on the wider social context of treatment-seeking, the child as a biological body also features centrally in parents discourses concerning treatment-seeking. Particular focus is upon the child's immune system. Within their accounts, parents express an understanding that preserving child health is not solely or necessarily about preventing illness or disease, rather it is also about having a strong immune system. For these parents, child health is maintained and preserved by promoting the development of a strong immune system and a part of this is avoiding anything that may damage or weaken the child's fragile underdeveloped immune system. This finding is similar to that of Bond, Nolan, Pattison, and Carlin (1998) who found that mothers' perceptions surrounding childhood

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immunisation included the belief that one component of good health was preventing disease: another was having a strong immune system.

When a child becomes ill the biological body, in particular the immune system, becomes the subject of tension that stretches from dealing not only with the immediate illness but to the current and future health of the child and children in the wider community. Such tension centres around introducing as little artificiality as possible, particularly in the form of medicines, into the child's body, and for conventional medicines to have as little impact or adverse effect on the child's body and immune system as possible. In doing so, risk to children's bodies and ultimately their health is limited. Within these accounts parents express a concern regarding the effects of conventional medicines upon the child's body and immune system, in particular, the effects of antibiotics. This concern is presented as significantly influencing whether or not parents take an ill child to the doctor and their compliance with medicine use advised by the doctor. This finding is consistent with those of previous research that reveal, for example, that parents often have reservations about giving powerful medicines to infants and that this may constrain their use of antibiotics (Kresno, Harrison, Satisna, & Reingold, 1994).

Woven throughout these accounts are parental constructions of conventional medicines, such as antibiotics, as unnatural, strong, and potentially harmful to children's bodies, in particular their developing immune system, and the wider community. As mentioned in the previous chapter, these constructions work to

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establish the use of conventional medicines as involving a risk to children's bodies and ultimately their health. Parents draw on these constructions to legitimate and defend their concerns and actions regarding treatment-seeking.

The following quotes from Sue and Gill provide examples of parents talking about their concern for the risk of conventional medicines and how this affects their decisions to take an ill child to the doctor. Firstly, Sue talks about why she often waits before taking an ill child to the doctor. In doing so, she describes herself as often in "two minds" or "torn" between a concern for the ill child and a concern for the effects of the overuse of antibiotics. Secondly, Gill talks about often not taking an ill child to the doctor due to a concern regarding the effects of antibiotics on the child's immune system. In relation to this concern, in another quote, Gill talks about often not administering the full amount of antibiotics prescribed by the doctor.

**Sue:**

Well I'd just like to get away from this over-use on antibiotics, because I also worry about the effect on the wider environment. That's one I didn't mention before. You know, increasing resistance to antibiotics in the community. So the rise of super-bugs and all of that, and this may not have any effect on my particular children, but you think of future children to come and the reduction in the number of effective drugs, and the ones that they do have having to be made more and more powerful, and it worries me that it's like interfering with the natural order. I'd rather that they get through it on their own and that their bodies develop their own resistance. But the GP would disagree with me on that, and say that it's got no long-term effects on them and not to worry - you should treat each infection on its own. It's just that they hate having this

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and I hate giving it to them because I feel torn, I'm in two minds about it. I don't 100% believe that it's actually going to do them any good anyway, so I don't like giving it to them.....I hate them being on antibiotics. Both my husband and I are quite pro natural medicine, and both of these two children unfortunately have had a lot of antibiotics during their short lives. Despite me always saying to the doctor "I don't want them to have this unless it's essential," and almost always he says, "Well, it's essential." So that is in our minds when we decide well, we won't go today - we'll wait till tomorrow to make an appointment.....I'm very concerned about the long-term effects of children having too many antibiotics. Effects on their teeth, and teeth that might not have come through yet, and effects on the immune system.

**Gill:**

I know that our GP will not prescribe antibiotics. He's very strict about that and he does not like antibiotics. He doesn't like the long-term effect it has on your body. And so I tend not to go, you know, if I think the children have a viral infection. Colds and flu are viruses so we don't go to the doctor for that sort of thing.... I was fed a lot of antibiotics as a child so I had a suspicion that our immune systems had been altered as a consequence of that. As a result, I've tried to ensure the children have as much...as wider variety in their diet and as much healthy food in their diet without being fanatical.... And I actually go along with my doctor's view that as few antibiotics as possible is beneficial to their immune system. So, yeah, I try not to have them treated as much as possible.

**Gill:**

I'm probably a bit naughty at giving them. Like if I say, when she's on - and been on - antibiotics and is fully recovered, and has..I've been still dosing her for another 5, 4 days, I can't remember. I think they go for 6 to 7 days. Since it's cleared I generally won't give her the last bit.

Evident in these accounts is that not only is there tension with regard to the harmful nature, and thus risk, of antibiotics but that this tension often transfers

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into a dilemma between the positive and negative aspects of antibiotics as conventional medicines. Parents often present themselves as 'torn' between conflicting constructions of conventional medicines, such as antibiotics, as harmful yet also beneficial to the child. They are caught between going to the doctor and having the ill child treated with conventional medicines and protecting him or her from the effects of these medicines.

This tension and dilemma are dealt with in various ways. For some parents, their concerns regarding the use of conventional medicines are put aside as they decide to seek professional help. Other parents attempt to resolve this tension and dilemma and limit the risk to the child's body by seeking help from an alternative health professional. Alternatively, parents may find a balance by delaying treatment-seeking and adopting some other means of caring for the ill child, such as using over-the-counter medicines or by, for example, halving the dose of medicines prescribed by the doctor. Interestingly, once again delaying or waiting to see the doctor is presented as an important tactic that enables parents to avoid using medicines until it is absolutely necessary. Further, this tension and dilemma are presented as an ongoing problem for these parents. It arises when first considering whether to take an ill child to the doctor and when, having visited the doctor and received a prescription, as evident in the last quote from Gill.

What is evident within parental talk is that it seems that they are trying to act according to what is considered the right thing to do regarding professionally

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legitimated boundaries of appropriate treatment-seeking, and in accordance with a conflicting concern for the child. Overall, this tension and dilemma are worked through in a manner that enables parents to depict themselves as good parents in terms of doing what is best for their own child's health and well-being and, at times, those of other children in the wider community. In doing so, parents draw on contradictory constructions of the child as both strong and fragile, childhood illness as serious and a normal, natural process, constructions of health professionals as the authorities, and the medical profession and scientific knowledge as imperfect. These constructions are variously drawn on, in conjunction with that of conventional medicines, to further legitimate or defend parents' actions by further establishing the use of conventional medicines and treatment-seeking as either risky or unnecessary, or as necessary.

In addition to the acceptance of the medicalisation of childhood illness as evidenced in the previous section, throughout parents' accounts there is also evidence of a resistance to such medicalisation. Parents often draw on ideas of childhood illness as a normal, natural process that aids in child health by strengthening the child's developing immune system, as opposed to being a biological malfunction. Further, it is often implied that medical intervention, such as antibiotics, is disruptive to this process. Within these accounts attention is focused on avoiding medical intervention to aid or facilitate this process. Such talk reflects a resistance to medicalisation through the conceptualisation of childhood illness as beneficial and not a medical problem or concern, and in

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doing so aids the depiction of medical intervention as unnecessary. This resistance to the medicalisation of childhood illness is evident in the quote above from Sue.

Interestingly, within these accounts parents may still talk of illness episodes when conventional medical intervention - such as Pamol - is necessary to treat or relieve a child. This not only illustrates how parents move between an acceptance and a resistance of the medicalisation of childhood illness, but it also suggests that - to a certain extent - parents are still dependent or reliant upon medical intervention and still accepting of the medicalisation of childhood illness. Overall, resistance to the medicalisation of childhood illness reflects the fact that parents do not necessarily passively and willingly accept medicalisation, but are often critical, active consumers. This is not to say that parents are any less dependent or reliant upon medical intervention, but simply that they are often critical of the need for such intervention. What is revealed here is that despite the dominance of medical thought throughout parents' accounts, this does not necessarily mean the acceptance of the medicalisation of childhood illness. Further, despite a resistance to such medicalisation, parents still have faith in modern medicine.

Within these accounts parents present themselves as knowledgeable and critical consumers of medicines - actively informed and aware of the risks of using antibiotics. In doing so, treatment-seeking is presented as an active critical process. Parents present themselves as taking an informative and critical

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approach to medical care use; establishing their treatment-seeking as comprising actively and critically making choices regarding adopting or accepting medical intervention, as opposed to doing so passively and uncritically.

In summary, an issue of concern for these parents throughout the process of treatment-seeking is the risk posed to the child's body and immune system, and ultimately his or her health. This concern is presented as involving tension and dilemma that impact upon how parents deal with childhood illness. Overall, treatment-seeking is positioned as taking place within a context of converging understandings of the child's biological body, conventional medicines, and child health. Within this framework, treatment-seeking is not just about and encompassed by concerns regarding treating childhood illness, it is also about limiting the risk, imposed by conventional medicines to children's bodies and ultimately their health. It is also often about finding a balance between this concern for treating the ill child and a concern for the risk of the effects of conventional medicines. Altogether, this reduces treatment-seeking to a biological issue and establishes this as a process, occurring within a particular social context, that is inseparable from caring for the child's immediate and future health in terms of limiting risk.

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**DEALING WITH ROLE CONFLICT AND BARRIERS TO CARE**

In addition to a concern for limiting risk, parents also talk about various barriers that prevent them from seeking treatment. Within their accounts, parents generally praise the accessibility and availability of child medical care services and talk of visits to the doctor as being made easy because of this and, in particular, the policy on free child medical care for children under 6 years. Despite all of this, parents still present their ability to utilise these services as being constrained by multiple barriers. Consistent with previous research (e.g., MOH, 1999b, Zaman et al., 1997) these barriers consist of various practical factors, such as having no transportation, and competing priorities and demands, such as having to work. My analysis reveals that these competing priorities and demands are framed as problems associated with the various roles that these parents fill in their daily lives such as being a parent, including being a 'good parent', housewife/husband, and/or career person, and the various commitments and obligations that each of these roles entails.

Throughout their accounts parents present the parenting role, including the good parent ideal, as demanding a response to the environment and daily life in a way that extends to accommodate the child. This role also involves meeting various demands and obligations surrounding a primary moral obligation regarding caring for the child and the child's health and well-being. Alternatively, the other roles that parents may fill, such as that of a career person, are presented as demanding a response to the environment not in a

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manner that accommodates the child, but as an individual. Further, these various roles involve a set of demands, obligations, and commitments that often conflict with the parenting role, such as those surrounding maintenance of a working career.

When a child becomes ill these conflicting or opposing demands, obligations, and commitments become competing demands, obligations, and commitments. An obligation to take the child to the doctor when he or she is ill may compete with, for example, work commitments or other demands within the parenting role, such as caring for other children in the family. Within their accounts parents often present such competing demands, along with various practical barriers to seeking care, as a significant source of tension and dilemma in terms of treatment-seeking, and parents are often caught between these conflicting roles or between various practical barriers to seeking care and a concern for the child. Parents attempt to deal with this tension and dilemma in various ways that include disrupting their work commitments to take a child to the doctor, or by seeking care as soon as the child becomes ill so that the child can be treated and recover quickly, in a manner that causes minimal disruption later to work commitments. Additionally, parents may attempt to resolve this tension and dilemma by finding a balance between such competing obligations and between barriers and an obligation and concern for the child by delaying treatment-seeking until it is absolutely necessary and administering over-the-counter medicines in the wait or seeking advice from a nurse or a chemist. The following quotes from Sue and Debbie provide examples of this tension and

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dilemma and how they are resolved. Firstly, Sue talks about often delaying treatment-seeking due to work commitments. Alternatively, Debbie talks about seeking treatment so that she can meet her work commitments with minimal disruption. Within this account Debbie describes herself as trying to 'balance' between treatment-seeking and meeting work commitments and the financial cost surrounding having a sick child.

**Sue:**

Well, I guess because my husband and I both work full time we are a really busy household and the children are in day-care full time. It is quite a big thing to take time off work for one of us to take him to the doctor, and maybe we put it off longer than we should do. I don't know, but with this latest episode we left it a few days and we had, maybe, three really bad nights with this baby before we thought, "We definitely have to stop here and take stock and see what's going on".... Chicken-pox is fairly mild and pretty run-of-the-mill but with both of us so very stressed about work and with big diaries every day full of appointments, anything like that which disrupts the normal running of the day is a major hassle, really, and requires a lot of juggling. So that probably sounds pretty self-centred because it's not worried about the child or the illness from their point of view, it's worrying about its effect on us and consequently on the whole family, the workings of the household.

**Debbie:**

Ah, it's a hard one to balance because at the same time we're both working full time and he's in child care three days a week. So it's a hard one to balance, and us have lots of time off work and him have a lot of time off child-care, which we pay a lot of money for, and also you don't like to see him sick, you want him to get well as soon as possible. So, yeah, it's a hard balancing act that one. It depends on how sick he is. Like, if he's very feverish, we'll take him to the doctor rather than leave it just in case it gets worse.... Because now we're both working really hard we both need to be at work. It's probably just

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to get him healthier quicker so we can get back to work. Whereas, if I was at home with him, I wouldn't matter as much.

Once again, what seems apparent within parents accounts is that they are trying to do the right thing for the child, but within the context of certain constraints. Further, woven throughout these accounts are contradictory constructions of illness as serious and a normal, natural process and of the child as both strong and fragile. These constructions are variously drawn on to legitimate and defend parents' decisions and actions by establishing treatment-seeking as either necessary or unnecessary. In this way, parents are able to present themselves as meeting their moral obligations towards the child and in doing so present themselves as good parents. This demonstrates how this tension and dilemma are resolved or worked through in a way that presents parents as doing what is best for the child.

In summary, these parents present treatment-seeking as constrained and shaped by various barriers. These barriers are often manifested in the contrasting and competing demands of the various roles that these parents fill in their day-to-day lives. Overall, parents present their treatment-seeking as shaped by the immediate environment within which childhood illness and treatment-seeking occur. In this way their treatment-seeking is placed in a rational light, and set within the actual circumstances and constraints of everyday life. In doing so, responsibility for treatment-seeking is shifted to inflexible constraints or factors that are not necessarily within the parents' control. Within this setting treatment-seeking is more broadly established as a

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process that is not simply about caring for an ill child, it is about doing so within the context of various practical barriers and meeting various demands, commitments, and obligations that form a part of being a good parent, housewife/husband, and career person. In this way treatment-seeking is depicted as a process that not only takes place within a social context, but one which is also placed within the immediate environment within which it occurs. Moreover, it is rooted within the context of fulfilling social roles, and as inseparable from this context.

#### CHAPTER DISCUSSION

Examined within this chapter is the highly variable and complex nature of treatment-seeking, evident in the accounts of these parents. The findings reached will now be integrated, as represented schematically in Figure 1.

Apparent within parents' accounts is the construction of treatment-seeking as a process comprising parents' constantly negotiating various issues and concerns characterised by tension, conflict, and dilemma. These issues and concerns consist of appropriate medical care use, the risk of medicines to the child, various barriers to seeking care, and competing demands and priorities. These are represented in Figure 1 as immediately surrounding "Treatment-Seeking".

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In general, these parents construct their treatment-seeking as a complex process that involves continually struggling to resolve and balance tension, conflict, and dilemma surrounding these issues. In doing so, parents' talk was always variable and changing to ensure they were presented as good parents. The negotiation of these issues and concerns was constructed as resulting in an array of pathways that enable parents to deal with - or resolve - this tension, conflict, and dilemma. These pathways include parents' choosing to wait, or to consult a doctor, nurse, pharmacist, social networks, or an alternative health professional. However, the negotiation of these issues does not stop once parents decide on a strategy for dealing with the ill child. Rather, the negotiation process is ongoing, with parents facing these issues and concerns not only when initially considering whether or not to seek treatment, but also once they have received advice or a prescription from the doctor, or when they need to return to the doctor.

The findings in this chapter demonstrate that treatment-seeking involves more than a mere response to a set of symptoms. Rather, it is a complex process of many elements beyond this, as various issues and concerns arise and are resolved within the context of being a good parent, preserving child health, the immediate environment within which childhood illness and treatment-seeking take place, fulfilling social roles, and individually and socially shared understandings of, for example, conventional medicines and the good parent. Ultimately, treatment-seeking is depicted as taking place within the context of these varying elements. This is illustrated in Figure 1 with these various

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elements being represented in a circle surrounding the various issues and concerns parents face in seeking treatment.

The findings in this chapter reveal that parents depict their treatment-seeking as taking place within a context of and being shaped by a socially and professionally legitimated framework of appropriate medical care use that is linked to socially shared ideas regarding what it is to be a good parent and what a good parent would do. With regard to this context parents construct their treatment-seeking as involving a concern for appropriate health care use. Ultimately, treatment-seeking is depicted as taking place within a social context that greatly impacts upon parents' decisions and actions regarding seeking treatment.

Parents also construct their medical care use as comprising a concern for the risk involved in going to the doctor and being prescribed medicines, such as antibiotics, for the child. Treatment-seeking is presented as taking place within the context of converging understandings of the child's biological body, conventional medicines, and child health. Further, treatment-seeking is depicted as an active critical process that takes place within a context of efforts to preserve the child's immediate and future health in terms of limiting risk to the child's body and, in particular, immune system. Overall, treatment-seeking is depicted as not only taking place within a social context but also occurring within a context of, and inseparably from, concerns and efforts to maintain and foster child health.

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Parents also construct their medical care use as involving a concern for - and struggle with - various practical barriers to care and between competing demands and priorities that form a part of the various roles they play in their day-to-day lives. Treatment-seeking is conceptualised as being about caring for an ill child within the context of the practical constraints of doing so, and meeting the various demands and priorities involved in being a good parent, housewife/husband, and career person. Thus, parents depict their treatment-seeking as not only taking place within a social context but also as rooted within, and inseparable from, the immediate environment within which childhood illness and treatment-seeking take place and the context of fulfilling social roles.

As mentioned, parents construct this negotiation process as taking place within a wider social context that consists of a socially and professionally legitimated framework of appropriate treatment-seeking linked to socially shared ideas of what it is to be a good parent and what a good parent would do. This is a social context within which childhood illness is medicalised, and within which parents accept, resist, and shift between accepting and resisting this medicalisation. From this the negotiation of various issues and concerns, and the shifting between an acceptance of - and resistance to - the medicalisation of childhood illness, can be more broadly interpreted as reflecting a negotiation between what is the right thing to do, within a medicalised society, and parents' individual concerns, with parents constantly trying to do the right thing for the child. In this way, treatment-seeking is depicted as a socially

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based decision-making process, not simply a response to physiological symptoms, that is shaped and constrained by the wider social, medicalised, context within which it takes place. This broader context is represented in Figure 1 as the bigger circle encompassing everything else. What remains to be seen is how parents construct their use of Well Child services. Is this constructed in the same manner? This is the focus of the following chapter.

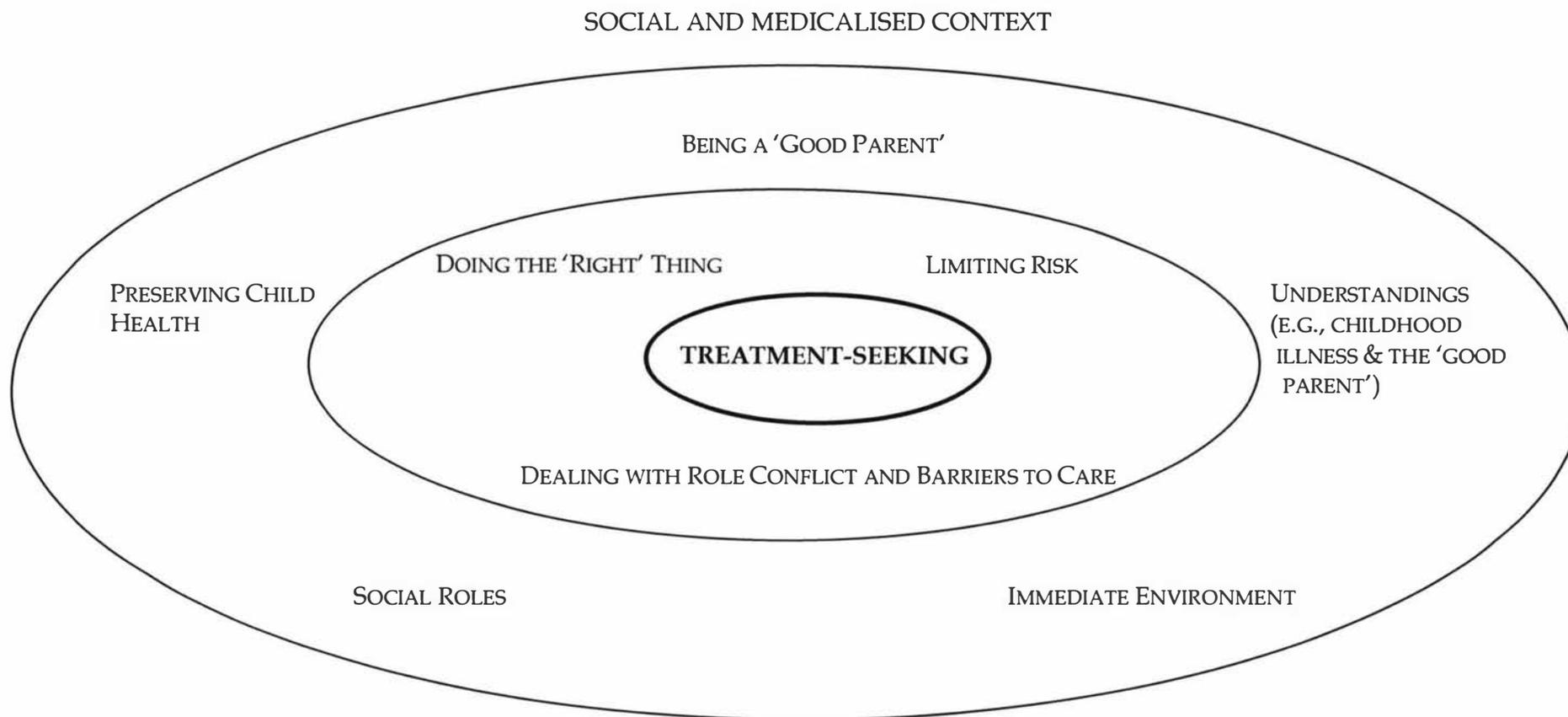


Figure 1. Schematic representation of the process of treatment-seeking.

## CHAPTER EIGHT

### CONSTRUCTING THE UTILISATION OF MEDICAL CARE: SEEKING HEALTH PRESERVATION

The focus of the previous chapter was on treatment-seeking for childhood illness. In caring for child health, parents are required to consider not only the issue of treating childhood illness but also issues of health maintenance and protection. The preservation of child health encompasses a range of activities including adopting various measures around the home, such as maintaining a hygienic living environment, having a balanced diet, and utilising the available medical care services. Two principal services affecting children in New Zealand are childhood immunisation and Well Child checks carried out by the Plunket society. These services form a part of the Well Child - Tamariki Ora programme. This programme is a Government initiative that offers a range of services that are aimed at providing not only support, information, and advice for parents, but also include free regular health checks - such as developmental, hearing, and vision checks - and free childhood immunisation for children. In this study parental talk regarding the preservation of child health and the

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utilisation of corresponding health care services centred primarily around the use of Well Child checks and childhood immunisation, with other efforts often being described as supplementary to the use of these services. Thus, the focus for this chapter is on the decision-making process surrounding the utilisation of these two services.

Generally, parents present the use of these two Well Child services as taking place within a context in which there is wide public and social acceptance and promotion of the presence and value of - as well as the need for - these services, particularly with regard to achieving high levels of immunisation to prevent disease epidemics. However, parents also talk of wide public debate surrounding the risks and benefits of childhood immunisation. The process of utilising Well Child services begins with parents being prompted by social networks or health professionals, for example. But adopting these services is not a simple matter of complying with such prompts. What is reflected in parents' accounts is that there is great variation in the adoption and continued use of these Well Child services such as parents choosing to fully immunise, partially immunise, adopt only specific immunisations, delay immunisation, space out immunisations, or use homeopathic immunisations.

As with treatment-seeking, these parents depict their utilisation of Well Child services as involving a decision-making process comprising facing and negotiating various issues and concerns, infused with tension, conflict, and dilemma that revolve around social expectations and pressures and the risk of

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immunisation to the child. These issues and concerns will now be discussed in turn.

### DOING THE "RIGHT" THING

As with treatment-seeking, the use of Well Child services is presented as taking place within a social context. Within their accounts parents depict their use of Well Child services as a social process; occurring within a context of, and shaped by, the shared values currently present and circulating within New Zealand society. In particular, it takes place within a context of shared ideas of appropriate Well Child service use that are linked to ideas about what it is to be a good parent and what a good parent would do.

The use of Well Child services is described as occurring within a social context within which parents are frequently prompted to have their children immunised or to attend Well Child checks. When discussing the use of these Well Child services, parents talk of being prompted to consider their adoption or continued use by both health professionals such as midwives, doctors, and Plunket nurses, and friends or family, health campaigns and advertisements. Depicted within these accounts is that health professionals, parents' social networks, the wider parenting community, and the community in general often feature prominently in parents' talk about their use of these services. In particular, parents often talk of their decision-making as influenced by, or

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impacted upon by, what others such as health professionals, social networks, or the wider parenting community are doing, advise, or endorse. Further, the use of Well Child services is described as involving a concern about disapproval from others, that is, health professionals, social networks, the parenting community, and the wider community. In comparison to treatment-seeking, this concern surrounding the use of Well Child services is broader in that it involves a wider network of people, not just a concern for receiving disapproval or judgment from the doctor. Throughout these accounts parents reflect on the power of social expectations of the use of Well Child services that are held within society: it is expected that parents will have their children fully immunised and regularly attend Well Child checks. Within these accounts parents often refer to a feeling of pressure or obligation to conform to these expectations.

Apparent within these accounts is the fact that not only are there certain social expectations pertaining to the use of Well Child services, but that these are tied in with socially shared ideas of what it is to be a good parent and what a good parent would do, particularly in terms of being socially responsible. Woven throughout parents' accounts is the idea that the "right" or responsible thing to do is to have your children fully immunised and regularly checked by the Plunket nurse. Failing to do so is often perceived as either placing the immediate child, and often other children in the community, at risk or as being irresponsible and socially deviant. Interestingly, again socially shared ideas of

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what it is to be a good parent arise within parents' accounts, except in this case they arise within the broader context of fulfilling social expectations.

Parents present these social expectations, and a feeling of pressure or obligation to conform, as issues that are often the cause of tension impacting upon their use of these services. Apparent within these accounts is the fact that parents often experience a conflict between what society expects of them and what society considers to be a good parent thing to do and what they feel is the right thing to do for their child, or what is necessary. Such talk is apparent in the following quotes from Samantha and Megan. Firstly, Samantha talks about the pressure she felt from others to have her child immunised and how this greatly affected her final decisions, implying that she may have decided otherwise if it had not been for such pressure. Further, Samantha talks about a feeling of pressure from others to attend Plunket Well Child checks. Secondly, Jo discussed why she immunised her children and in doing so she talks about initially immunising because this is what responsible parents do, but then later on considering the side-effects of immunisation. In this account, Jo highlights how the decision to go against the mainstream is a big thing implying that this concern contributed to, or played a role in, her final decision.

**Samantha:**

Plunket was really pushy. And then Homer and Marge [the grandparents] telling me I should have him immunised. And even from day-care there was this pressure. Basically, Richard has had the last lot of immunisations because of peer pressure. I left it a little longer because I was having trouble deciding.

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I had heard that there were these really bad side-effects but then there were notices going around day-care saying that there are outbreaks and telling you to immunise your child. And having to say whether your child is immunised or not and causing segregation between immunised and nonimmunised. And if you decide not to I reckon you still get viewed differently and outside of the group. I think if I hadn't have done it I would have felt left out. I think other parents either think of you as ill-educated or poor or something like that. You know, like you didn't know to do that. Not simply that you were educated enough to make a decision. And you know, because this is the first time, your first kid, you don't want to screw up and everyone looks at you and you feel a lot of pressure to do good. And you get the blame as the parent if the child got sick....I felt obliged to go to Plunket 'cause that's what you did and there is a lot of pressure. You know, the grandparents were always asking, "When is your next appointment?" and "What did the Plunket nurse say about Richard, what is his weight?" I didn't like Plunket so I didn't go. And I stopped telling people, never told the grandparents I wasn't going.

**Jo:**

The first one I immunised because you immunise them. You know, you just did it. I mean, I was a responsible mother - so I got them immunised. Ah, the second one much the same. The third child I had quite a lot of misgivings about doing it. I guess there was more publicity about possible hazards of immunisation. I've got a, my husband's cousin has got three children who she hasn't immunised and I met up with her in the interim and she not brow-beated me, but asked her why hers weren't immunised and, yeah, I just had a few alarm bells ringing about it. And I did, we spent a lot of time weighing up "Will we, won't we? Will we, won't we?" and to go against the mainstream is quite a big thing. And then we thought, "Right we will" - but I didn't like it much with the third child.

This tension is generally dealt with in various ways including parents' buckling under, or giving into, such pressure and complying with social expectations.

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These findings are similar to those obtained by Hardy and Bolden (1984) who found that a group of mothers who vaccinated their children appeared to have done so to conform with what was expected.

This tension is worked through in parents' accounts in a manner that enables them to legitimate and defend their accounts and present themselves as good parents; as looking after the best interests of the child. That is, within their accounts parents draw on various constructions - such as childhood disease as serious and a normal, natural process, childhood immunisation as unnatural, strong, and potentially harmful to the child - that work to establish the use of Well Child services as either necessary or unnecessary.

As mentioned earlier, child medical care use is immersed within a context in which child health, illness, and disease are medicalised, with evidence within parents' accounts of an acceptance, or resistance, and of parents shifting between an acceptance and resistance of this medicalisation. In particular, apparent within these accounts surrounding the use of Well Child services there is evidence of an acceptance of this medicalisation. For instance, these parents often talk about attending Well Child checks for reassurance that their child is normal and healthy. In doing so parents present themselves as reliant or dependent upon a set of biomedically defined standards, limits, and boundaries to establish whether or not their child is normal and healthy. Further, in relation to this, attention is given to a dependence upon health professionals to monitor and assess or evaluate the normality or health status of

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their child according to these standards. Within these accounts, to a certain extent, the role and responsibility of monitoring and assessing a child's health is transferred from the parent to the health professional. Such talk reflects an acceptance of the medicalisation of child health in the form of both relying upon biomedical definitions of normality and health and relying or depending upon health professionals to monitor the health and development of the child. Such medicalisation focuses attention on the need to utilise these Well Child checks. The following account from Sally provides an example of such talk.

**Sally:**

Um, I guess because I wanted to make sure. Especially with Helen. Especially with your first, you desperately want them to be average and normal. And I think that was that the...and Helen was so tiny. Never even got on the graph ever. And so that was a pain in my life. One of the smallest children and oh, it was hard work really! Because it was, like, "Don't you feed your child?" She ate really well and she still does and she's still tiny. But, um, and once again she was so tiny and a lot smaller than everyone else.... And she's still small but she's not now. She's not now that we need to worry about that...but the first-born was. So I probably went to Plunket for reassurance and that she was doing everything else. Making all the other milestones like sitting up and crawling and walking. All those height and weight were lagging behind.

With regard to using Well Child checks, some parents express an objection to the biomedical definition and measurement of a normal or an ideal healthy child that is established and endorsed by health professionals and Plunket. Such talk reflects a resistance to the medicalisation of the preservation of child health and in doing so aids in depicting the use of Well Child checks as

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unnecessary. The following quote from Megan provides an example of this resistance.

**Megan:**

Well, if you mean weighing and measuring - yeah, no - I really don't. That's one reason I don't like Plunket 'cause I don't like that whole idea of, um, ideal weight and you know. It's a bit ridiculous. So, um, no I mean - and I think - you'd know. I mean, I honestly think you'd know. I mean, you look at him - he's a big boofy looking baby, I think you would know. No, I don't particularly. Obviously I watch and make sure they're not ill and if they were ill all the time I would be concerned - but I just have got no worries.

This quote reflects not only a resistance to the medicalisation of child health in the form of resisting a biomedical definition of normality and an ideal healthy child, but also a resistance to the medicalisation of child health and development in the form of resisting the control or dominance of the medical profession over these issues. Within these accounts some parents express a dislike of the idea of having the medical profession establish, evaluate, and monitor the health of their child, and emphasis is often given to the ability of parents to be able to do this themselves without the use of health professionals. In doing so, parents validate their expertise and ability in preserving child health. Such talk not only reflects a resistance to the medicalisation of child health, but in doing so, aids in depicting the use of Well Child checks as unnecessary. In addition to Megan's quote above, further evidence of this resistance to the control and dominance of the medical profession is apparent in the following quotes from Cath. Firstly, Cath talks about deciding against

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continuing with childhood immunisation due to, among other things, a perception of an attempt at social control by the medical profession. Secondly, Cath talks about discontinuing her use of the Well Child checks due to both an objection to the control of Plunket over parents, and to her confidence in her own ability to monitor her child's health.

**Cath:**

I decided that I wasn't convinced that was the best way to go...there's not enough evidence - medical evidence - to say that the immunisation programme hasn't been running long enough for me to know that in 20 or 30 years vaccinating her as a child is the right thing to do.....This is at the initial consultation - it came out that the reason it's at 6 months is that coincides with the mother's visit. And I decided that wasn't a good enough reason. It's sort of saying that women can't make up their own minds to go back a bit later so we had better grab them now. So I just said, "No, it's too young."

**Cath:**

We went along to the Plunket nurse about - I don't know whatever it was - every couple of months or whatever the schedule visits were after that, but when she was - I think the last time she went - she was 8 months old. And I haven't been back since, and I haven't felt any need to, and I didn't feel that anything that came out of Plunket was okay. Yeah, it's interesting to see how much she weighed and how long she was...but other than that...I think that I went along to one Plunket thing and I felt that...I don't want to put Plunket down, they can be quite helpful. But I think that women probably know more than they think they do and it's easy to rely on experts to tell you how to do things. I can remember being at one Plunket thing and a women asked if it was okay if you stand your young baby upright on its feet. And I thought, "Gosh, you know, if women have got to the stage they have to ask if they can do something that I wouldn't even think twice about doing then that's a shame"! So, I think having something like Plunket is great. If you've got a concern, then you go - and if people like the reassurance, then that's fine, too.

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But I didn't feel that there was anything wrong. I knew Angela was growing - she was growing out of her clothes. It was obvious she was growing - she felt heavier. It was obvious she was putting on weight. She was obviously happy, and so starting to develop in various ways.

As with treatment-seeking, this resistance to medicalisation demonstrates that parents are often critical active consumers of medical thought and dominance. When considering the construction of health professionals as having limited knowledge, such resistance to their advice and guidance is not unexpected. But evident within these accounts is that this resistance is not solely related to parental constructions of health professionals as possessing limited knowledge. Rather, these accounts also signal that underlying this resistance is a struggle for autonomy.

As mentioned earlier, despite that these parents' construct health professionals in a knowledgeable and authoritative manner, they are not constructed as having total control or power over the parent. In fact, parents construct their relationship with health professionals as one in which they, as parents, exercise a degree of autonomy, control, and power to the extent that there is symmetry in knowledge, power, and control between parents and health professionals. In this respect, health professionals are constructed as partners in the health management of children. In the quotes mentioned above the resistance to the guidance and advice of health professionals reflects a certain amount of resistance to the dominance of doctors. That is, there is a reluctance or resistance to relinquishing themselves and their control over the child to the

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dominance of health professionals. Instead, these parents are taking matters into their own hands and retaining a sense of independence and autonomy, power, and control along with a sense of partnership between themselves and health professionals.

In summary, the analysis reveals that these parents do not necessarily use Well Child services solely due to an immediate understanding that doing so is beneficial to the child. Rather, the use of these services often involves a feeling of obligation towards fulfilling certain societal expectations that relate to being a good parent. However, there is often conflict surrounding these expectations and the use of Well Child services. From this it is established that the use of Well Child services does not occur in isolation. Rather, it is a process embedded within a context of social forces and wider socially shared ideas about what it is to be a good parent and what a good parent would do.

### **LIMITING RISK**

In addition to this concern with social expectations parents talk also of their decisions surrounding the use of Well Child services as involving, and influenced by, a concern for the risk of childhood immunisation to the child. Within parents' accounts childhood immunisation is presented as a unique issue that differs from the use of Plunket services in that it is encompassed by great public debate that centres around the risk that childhood immunisations pose to the health and development of the child. Parents generally present

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their decisions about childhood immunisation as taking place within this context and, as a result, involving a complex process of becoming informed and weighing up the pros and cons of childhood immunisation; carefully deliberating, making an active and critical decision whether to immunise or not.

Interestingly, as with treatment-seeking, the biological child is a predominant focus within parents' accounts regarding the use of childhood immunisation. The biological child is the subject of tension and dilemma that involve introducing a minimal amount of artificiality into the child's body and for immunisation to have as little impact or adverse effect on the child as possible. In doing so, the risk of immunisation to the child's health and development is limited. Adopting childhood immunisation is presented within parents' accounts as not just being about - and involving - concerns regarding the prevention of childhood disease, it is also about limiting the risk of immunisation to the child. Further, it is often about finding a balance between preventing disease and limiting risk to the child caused by vaccinations. Such talk is apparent in the following quotes from Annette and Cath. Firstly, Annette talks about why she has not immunised her children and her struggle in deciding whether or not to immunise her daughter against rubella. In doing so, Annette refers to the effects of immunisation and to the effects of the disease upon the child. Secondly, Cath talks about her decision not to continue immunising her child as being due to a concern regarding the effects of immunisation upon the child's body, and in particular his or her immune system.

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**Annette:**

...If someone could convince me that it worked, and they could convince me that it was safe, then I'd be fine. It would be hard to do the safe part because of the preservatives put into it. I also know of a woman whose daughter was given one of them, one of them with egg in it, and they didn't ask the family anything about whether they had an egg allergy. So this poor child got very sick, very, very sick. And the woman was telling me that the daughter finally got better, and she told me that her daughter changed, she was a different child after this experience...And having that other woman in town whose son has been damaged by it, and I really just saw him in the lounge - but I thought what he was doing for his age, this must be really hard you know. He was about 11 and doing stuff a 3-year-old could do. Only the parents for a long time realised that the immunisation had done this...Who was it in Australia, they did a study on something else about still-births, and as part of their data collection they collected the immunisation records. No - it was about cot death. I'm assuming that the facts were...that it's correct factual information that she collected. Being...as a scientist she would have to make some assumptions somewhere, so if she found this correlation, not looking for it, between immunisation and stress and cot death. Well there's something to question... I don't know what I'm going to do once my daughter gets older and my boys get older. Because if they're not exposed to certain things they might get them later, or she might catch rubella when she's pregnant. So I'm on the fence. I don't know what to do. But if I choose to do it later I can at least be comforted that their bodies have developed. I have a problem giving it to their under-developed immune system. I'm looking at early teens; I would rethink if they haven't had anything.

**Cath:**

I took her. I don't actually totally support the vaccination programme. I'm not totally against it, and I don't feel comfortable with it either. And I was certainly not comfortable with taking a 6-week-old child for the first ones. And I delayed it until she was 4 months old. I gave her the first round of them or took her in for the first round. And then I read more on it and I decided that I wasn't convinced that was the best way to go. So I haven't taken her

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back. And I'm still open to being convinced that it is good. But I'm - in fact, I was listening to a debate on that diphtheria case that's breaking out this morning. And I'm still not convinced that, for example, I know I have no more immunity to diphtheria than my daughter. But there's a lot of discussion put into child immunisation but what people don't always say is that adults aren't given booster shots. So they're not immune either. So that's why - but if it was just a case of giving her a shot, that was it - immunity for life, 100% guarantees, then I'd say, "Fine!" But there's no guarantee. There's no guarantee that she won't react to the vaccine. There's no guarantee she won't get the illness. She won't be immune for life and so for that reason I haven't taken her back until I've...I feel perhaps more comfortable that the long-term effects of immunisation on the immune system is clear. And I'm not sure that that is clear at this stage. There's not enough evidence, medical evidence, to say that the immunisation programme hasn't been running long enough for me to know that in 20 or 30 years, vaccinating her as a child is the right thing to do.

**Interviewer:**

You mentioned you delayed her first vaccination. Why was that?

**Cath:**

Because I just felt that she was just so young. That to be hit with so many the... the what you call it, the germs - or whatever they are called, the substance. To be hit at that age was far too young and after talking to my doctor...like I say measles - if she gets it, she gets it - and I don't know how I could prevent that. In fact, I don't mind if she does get it. At least I know then that she does have lifetime immunity. And this is part of the problem I see with the programme is I don't think that necessarily the risk of, say, measles because it can turn into pneumonia or something. But I think if it's managed in the early stages that shouldn't happen. So then I don't do anything to prevent it other than like, say, some of it has to do with unhygienic living conditions. Well, most people don't live in the sort of conditions that are going to promote that anyway.

As mentioned in the previous chapter, for these parents the preservation of child health is not solely about preventing illness or disease, rather it is also

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about preserving and promoting the biological body, in particular the development of the immune system. Within these accounts surrounding the adoption of childhood immunisation, these parents express a primary concern regarding the effect of childhood immunisation upon the child's body and ultimately his or her health and development. Parents often present this concern as a source of tension and dilemma that significantly influences their adoption and continued use of childhood immunisation. These findings are similar to those of previous research - that a concern for the side-effects of immunisation - impacts upon the adoption of childhood immunisation (e.g., Bennett & Smith, 1992; Hardy & Bolden, 1983; Lannon et al., 1995; Lewis et al., 1988; Pruitt, Kline, & Kovic, 1995; Roberts, Sandifer, Evans, Nolan-Farrell, & Davis, 1995; Salsberry, Nickel, & Mitch, 1993; Stevens, Baker, & Hands, 1986; White & Thomson, 1995).

What is reflected in parents' accounts in this study is that this tension regarding the use of childhood immunisation often leads to a dilemma between the positive and negative aspects of childhood immunisation, with parents often presenting themselves as 'caught' between the beneficial and harmful nature of childhood immunisation. That is, they are caught between protecting the child from the risk of disease and protecting the child from the risk of the harmful effects of immunisation. Such tension or dilemma is dealt with, or resolved, in various ways with parents accepting the risks and fully immunising their child, choosing not to immunise and often adopting other preventative measures, or choosing to use homeopathic immunisation. Parents may also attempt to find a

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balance between these risks by partially immunising their child and adopting only specific immunisations, delaying immunisation, or spacing out the immunisations so that the child does not receive too many at once. Interestingly, as with treatment-seeking, delaying immunisations, along with partially immunising or spacing immunisations out, serves as an important tactic allowing parents to deal with tension and dilemma. Further, this tension and dilemma are presented as ongoing problems for these parents. Due to the ongoing nature of Well Child checks and childhood immunisation parents find themselves repeatedly faced with having to decide whether to utilise these services or not.

These findings are similar to those of Bond et al. (1998, p. 443) in a study of mothers' perceptions surrounding immunisation. These researchers found that mothers experienced a conflict in their decisions and actions to protect their children. In particular it was found that "a strong immune system was associated with the concept of good health. But vaccines were perceived as having a negative effect on the immune system...to be healthy, prevention of serious diseases was desirable, but while vaccination prevents serious disease, it was also associated with the belief that it weakened the immune system."

Throughout their accounts parents draw on constructions of childhood immunisation as unnatural, strong, and potentially harmful to the child's physical body, health, and development. These constructions work to establish the use of childhood immunisation as involving a risk to the child's physical

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health. In drawing on these constructions parents are able to legitimate and defend their concerns regarding adopting or continuing the use of childhood immunisation.

Parents also variously draw on contradictory constructions of the child as both strong and fragile, childhood disease as serious and a normal, natural process, parents' constructions of health professionals as the authority, and the medical profession and scientific knowledge as imperfect. Used in conjunction with constructions of immunisation, these constructions further legitimate or defend parents' concerns regarding the use of childhood immunisation. Further, these constructions are also used in a manner that enables parents to defend their decisions by further establishing childhood immunisation as either risky or by establishing it as unnecessary, or as necessary. Overall, this tension and dilemma are worked through in a manner that enables parents to depict themselves - despite their decisions being at variance with what is considered the right thing to do within society - as being good parents in terms of doing what is best for their own child's health and, at times, the health of children in the wider community.

Throughout parents' accounts surrounding the adoption of childhood immunisation is evidence of both an acceptance of, and resistance to, the medicalisation of childhood disease. Within their talk parents often draw on ideas of childhood disease as a biological malfunction that is potentially harmful to the child, and conceptualise childhood disease as something that

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should be prevented through medical intervention. In doing so, attention is given to a reliance or dependence upon medical intervention to prevent the child from contracting childhood disease, as opposed to, for example, enhancing living conditions. Such talk establishes childhood disease as a medical problem or concern and in doing so helps parents to establish prevention in the form of immunisation as necessary. The following quote from James provides an example of such talk.

**James:**

For two reasons not only for herd immunisation, to protect the whole community and also to protect individual children...and I guess the best example of that's polio. If we weren't vaccinating we'd still have polio, and I'm a very strong advocate of vaccination because of the reasons that we could still have these fatal diseases around if we didn't immunise on a global or population-based scale. And where we have epidemics of health problems is where a certain number of vaccinations aren't given to a critical number of people and then the epidemic breaks out. I feel duty bound as a member of the public to vaccinate my children, and also I would choose to do that for their own health reasons as well.

In addition to this acceptance of the medicalisation of childhood disease there is also evidence of a resistance to such medicalisation. Some parents recognise childhood disease as a biological malfunction, but one that is caused by social issues such as poor housing and one that can be controlled through dealing with such social issues. Additionally, parents often draw on ideas of childhood disease as a normal, natural process that aids in child health by strengthening the child's developing immune system. This is as opposed to a biological malfunction that is dangerous and a threat to child health. Further, it is often

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implied that medical intervention is disruptive to this process and attention is focused on avoiding medical intervention, such as immunisation, to aid or facilitate this process. Altogether, such talk reflects a resistance to medicalisation by conceptualising childhood disease as either something that can be controlled through means other than medical intervention or as beneficial to the child and not problematic. Doing so aids in depicting childhood immunisation as unnecessary. In this way the resistance to the medicalisation of childhood disease parallels that of childhood illness evident within parental talk surrounding treatment-seeking. The following quotes from Megan and Cath provide examples of this resistance. Megan goes even further in her quote in expressing a resistance to the conceptualisation of childhood disease as a medical issue by protesting the use of a biomedical solution to a social problem.

**Megan:**

The reasoning is that I think measles is a perfectly normal childhood disease. I mean, God, we had measles, we had mumps - and it's only I think when it's in, um, the low socio-economic areas that haven't got the hygiene standards or the good nutrition and the children are not healthy, then it's a problem. And the people don't recognise it so - of course - they suffer from a secondary complication, not necessarily the measles - you see what I mean?

**Cath:**

Like, say, measles, if she gets it she gets it and I don't know how I could prevent that. In fact I don't mind if she does get it. At least I know then that she does have lifetime immunity.

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Interestingly, there may be a resistance to the medicalisation of certain diseases and not others. Further, although there may be a resistance to the medicalisation of child health and disease there may be an acceptance of medicalisation of childhood illness in terms of treatment-seeking. This indicates that despite a resistance to medicalisation there is still a faith in, and reliance upon, the medical profession and medical intervention. In this sense, parents may sway back and forth between an acceptance and a resistance to medicalisation across their accounts.

In summary, what is demonstrated here is that parents do not always adopt childhood immunisation simply due to a feeling of obligation. Rather, parents often do so after a process of careful deliberation that revolves around parental concerns regarding the effects of immunisation upon the child. Once again parents present themselves as knowledgeable and critical consumers of medical intervention, and as making an active choice whether or not to adopt childhood immunisation. Further, utilising childhood immunisation is depicted as an active critical process that occurs, not only within a context of social forces but within a context of understandings regarding the child's biological body, conventional medicines, and child health.

### CHAPTER DISCUSSION

The process of utilising Well Child services begins with parents being prompted by, for example, social networks or health professionals. However,

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the findings in this chapter reveal that adopting these services is not a simple matter of complying with such prompts. I will now turn to integrating the findings in this chapter (represented schematically in Figure 2). In the process I will also point out and discuss the similarities and differences between this process and that of treatment-seeking.

As with treatment-seeking, surrounding the use of Well Child services is a complex process comprising parents constantly negotiating various issues and concerns characterised by tension, conflict, and dilemma. These issues and concerns consist of social expectations and pressure and the risks of immunisation to the child. These are represented in Figure 2 as immediately surrounding “Seeking Health Preservation”.

In general, as with treatment-seeking these parents construct their use of Well Child services as involving a complex process of continually struggling to resolve and balance tension, conflict, and dilemma surrounding these issues. Again, in doing so, parents’ talk was always variable and changing to ensure they were presented as good parents. These parents construct these issues as negotiated in various ways that result in an array of pathways being taken that enable parents to deal with or resolve the tension, conflict, and dilemma surrounding these issues and concerns. These pathways include parents choosing not to take a child to Plunket checks, parents choosing to fully immunise their child, not immunising their child at all and often adopting other preventative measures, choosing to use homeopathic immunisation, partially

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immunising their child and adopting only specific immunisations, delaying immunisation, or spacing out the immunisations so that the child does not receive too many at once. The negotiation of these issues and concerns is not a one-off thing. Rather, it is ongoing for these parents. Due to the ongoing nature of Plunket checks and childhood immunisation, and because parents may have more than one child under 5 years, the negotiation process is also ongoing as parents have to repeatedly make the decision whether to accept and adopt these services or not.

These issues and concerns that parents face in utilising Well Child services arise - and are resolved - within the context of being a good parent, preserving child health, and individually and socially shared understandings. From this, the use of Well Child services is depicted as taking place within this particular context. This context is represented in Figure 2 as the circle surrounding the issues and concerns parents face in seeking health preservation.

The findings in this chapter reveal that these parents construct their use of Well Child services as involving a concern regarding social expectations and pressure surrounding the use of Well Child services. In general, these parents depict the use of Well Child services as taking place within a context of, and being shaped by, the shared values and expectations currently present and circulating within New Zealand society. These shared values and expectations are linked to socially shared ideas about what it is to be a good parent and what a good parent would do. Surrounding these expectations is a feeling of

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obligation or pressure to conform that becomes a source of tension for some parents. Overall, the use of Well Child services is depicted as a process embedded within a context of social forces and wider socially shared ideas about what it is to be a good parent and what a good parent would do. As with treatment-seeking, this concern regarding the use of Well Child services involves a concern for doing the right thing. However, when it comes to using Well Child services this is placed within a broader context regarding receiving judgement or disapproval from not only health professionals but also from social networks, the parenting community, and the wider community. The similarity between this process and that of treatment-seeking suggests that doing the right thing is a concern that is ongoing for these parents independent of the service they are utilising. This similarity demonstrates the strength of the social nature of child medical care use. This also suggests that the issue of doing the right thing occurs in other aspects of parenting, but this is beyond the scope of the present study.

Additionally, parents construct their decisions surrounding the adoption of childhood immunisation as comprising a concern for the risks of childhood immunisation to child health and development. In doing so parents depict the adoption of immunisation as an active critical process that takes place not only within the context of wider social forces, but also within a context of understandings of the child's biological body, conventional medicines, and child health. This issue is similar to that which parents negotiate in treatment-seeking concerning the use of conventional medicines such as antibiotics. The

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similarity of this issue with that of treatment-seeking is not surprising considering parental general constructions of conventional medicines such as antibiotics and vaccinations.

With regard to the difference between this process and that of treatment-seeking, parents presented treatment-seeking as involving certain constraints and barriers that consist of practical factors and competing priorities and demands such as having to work. Although adopting Well Child services is presented as taking place within the context of practical barriers and competing demands and priorities that form a part of the various roles that they play in their day-to-day lives, these were not presented as a significant issue or concern impacting upon their adoption of Well Child services. The reason for this is that there is no sense of urgency when it comes to using Well Child services as there is when considering seeking treatment.

Further, as mentioned, this negotiation process is constructed by these parents as taking place within a wider social context that consists of social forces and socially shared ideas of what it is to be a good parent and what a good parent would do. This is a social context within which child health and disease are medicalised and parents are accepting, resisting, and shifting between an acceptance and resistance of this medicalisation. As with treatment-seeking, the negotiation of various issues and concerns, and the shifting between an acceptance and resistance of medicalisation, can be more broadly interpreted as reflecting the negotiation between what is the right thing to do, within a

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medicalised society, and parents' individual concerns. However, with regard to using Well Child services in particular, the analysis has revealed that this negotiation can also be interpreted as involving a struggle for parents between a medicalised society and personal autonomy.

From the analysis presented in this chapter it can be concluded that the adoption of the Well Child services, Well Child checks and childhood immunisation is a socially based decision-making process that involves the ongoing negotiation of various issues and concerns. Again, this broader context is represented in Figure 2 as the big circle surrounding the others. Overall, in comparing the analysis in this chapter with that in Chapter Seven it can be concluded that both caring for child health in terms of seeking treatment for episodes of childhood illness and adopting Well Child checks and childhood immunisation are similar processes but that they differ on a number of dimensions.

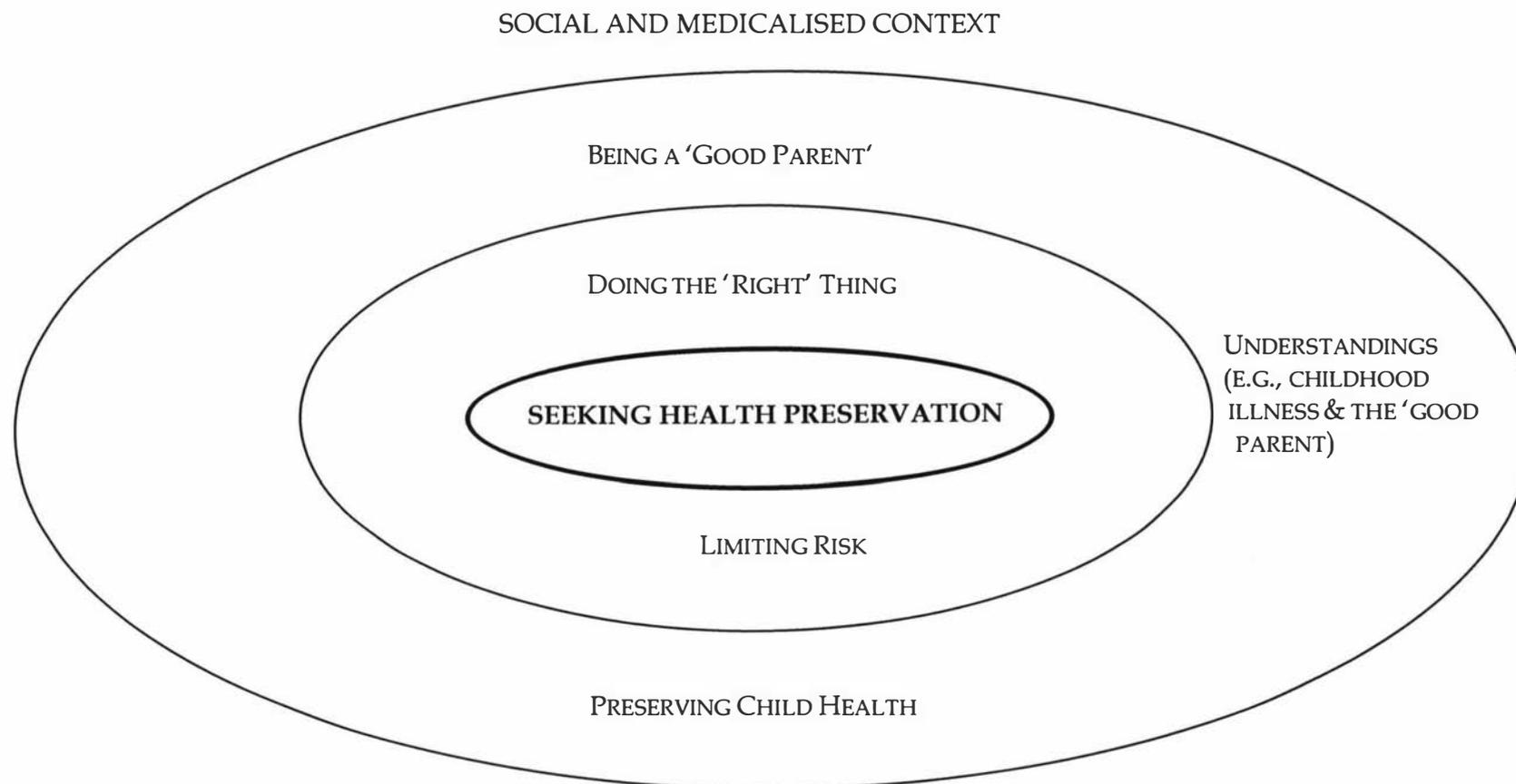


Figure 2. Schematic representation of the process of seeking health preservation.

## CHAPTER NINE

### GENERAL DISCUSSION

Through a social constructionist stance that unites a realist ontology with an epistemology of constructionism, and with the use of grounded theory methods, the current research project sought to explore parental talk regarding child medical care use. The specific objectives of this investigation were to examine and explore parental talk surrounding the use of treatment and preventive-oriented services. In doing so, my aim was to develop an understanding that fills the gaps in current understanding in this area. In particular, my aim was to achieve this through adopting an approach that provided a flexible and open means of investigating parents' understandings, by capturing the complexities of medical care use - including conceptualising this phenomenon as a complex process - and contextualising such service use. Additionally, by fostering discovery and capturing the lived world of the participants it was hoped that this investigation would provide important information from which a substantial basis for the development of effective initiatives aimed at improving child health could be achieved. Within this chapter some general observations are made and the contributions which this

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investigation makes to this area – and their implications – are discussed. The chapter concludes with a discussion of the limitations of this project.

### GENERAL OBSERVATIONS

Analysis of parental talk surrounding child medical care use reveals that parents draw on complex and contradictory constructions regarding the child, the parenting role, the medical profession, childhood illness and disease, and medicines. Analysis also shows how such service use takes place within – and is shaped by – these complex understandings. For example, the findings demonstrate how medical care use takes place within – and is often shaped by – individual and socially shared understandings of what it is to be a “good parent” and what a “good parent” would do. Another example is that of parents’ service use often being shaped by understandings of childhood illness and disease as normal, natural processes. By investigating such parental constructions, parents’ actions are placed within the lay arena in which issues of child health and illness are negotiated, decisions are made, and medical care activities take place; within parents’ own understandings.

By exploring parents’ constructions this investigation has also shown that these parents are not simply passive recipients of, nor necessarily persuaded by, biomedical dominance or perspectives. Rather, these parents construct the medical profession and medicines in different, complex, and contrasting ways

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that reflect a critical perspective and approach to the medical profession and to medicines and their use. For example, the medical profession is constructed as limited in knowledge and ability and conventional medicines are often constructed as unnatural, strong, potentially harmful, and as merely a treatment-oriented solution, as opposed to providing a cure. In doing so, these parents also construct themselves as critical consumers of medical care.

These findings support and contribute to previous research that delves into parents' understandings surrounding and influencing medical care use and has revealed various understandings of illness, disease, and medicines similar to those in this study (e.g., Colucciello & Woelfel, 1998; Cornford et al., 1993; Cunningham-Burley, 1990; Hunte & Sultana, 1992; Kviz et al., 1985; Taylor & Cufley, 1996; White & Thomson, 1995). This study also supports research that shows that people are not necessarily passive recipients of biomedical ideas but are often critical and active consumers of medical care (e.g., Stainton Rogers, 1991; Williams & Calnan, 1996a).

The results from this analysis also challenge previous research in this area that focuses on the identification of particular variables - such as socio-economic status - as risk factors for failure to use medical care services (e.g., Essex, Counsell, & Geddis, 1993; Rainger et al., 1998; Shannon, Fergusson, & Clark, 1980). In particular, this study challenges research that approaches such an investigation from a biomedical perspective. For instance, such research often fails to consider parental understandings surrounding medical care use and in

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doing so, this research often portrays lay people as uncritical and passive recipients of the biomedical perspective.

Within this study the aim of exploring parental constructions was to provide a backdrop from which to begin to understand how parents construct their medical service use. But, the analysis uncovers more than this. That is, this study demonstrates how parents often struggle with their constructions and the contradictory nature of these. For example, in times of uncertainty parents often struggle between a construction of children as strong and resilient and a construction of children as fragile and vulnerable. Parents also seem to struggle with contradictory constructions of childhood illness and disease as harmful to a child's body, health, and general well-being (necessitating medical intervention), and as normal, natural processes that serve a beneficial purpose for the child's body and health (not necessitating medical intervention). There is also evidence of parents struggling with their constructions of medical intervention as both beneficial for the child and as involving risk, such as, imposing harm onto the child's body. By revealing how parents often struggle with the diverse and contradictory constructions that they hold, this study extends upon previous research that simply stops investigation at the identification and description of such constructions.

This study also challenges previous research that ignores the broader, including social, context of child medical care use and the parent in interaction with this context. For instance, previous research often focuses on the individual

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cognitive processes involved in service use, ultimately portraying this use as a result of purely cognitive assessments (e.g., Kviz et al, 1985; Pacis, 1990). Such research raises the importance of individual cognitive processes involved in service use, however, it does so at the expense of diverting attention away from or downplaying the broader context in which decisions and actions take place; downplaying environmental factors and producing a decontextualised account. Other research has attempted to focus on the individual cognitive processes involved by investigating environmental factors - such as barriers related to medical care service factors - influencing or playing a role in medical care use (e.g., Cutts, Orenstein, & Bernier, 1992). However, once again it can be argued that such research still neglects to look at the wider and social context in which service use takes place.

Within this study parents construct caring for their child as involving a negotiation (of various issues and concerns) process that takes place within a wider social context. This is a social context within which the biomedical perspective is dominant and medicalisation is apparent.

Within the biomedical perspective there are a number of assumptions regarding what illness is, how illness should be treated, and by whom. This perspective regards illness and disease as deviations from measurable biological norms (Engel, 2002). Illness and disease are considered dysfunctional and medical care is considered a necessity as it provides the only solution to this dysfunction (Research Unit in Health and Behavioural Change, 1989). The

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biomedical perspective holds that the most rational and accepted course of action is biomedically defined with the medical establishment defining what is appropriate and inappropriate. This perspective also claims an 'objectivity' based on scientific legitimacy which brings with it an unequal power relationship between doctors and patients. Within Western society, the biomedical perspective is considered the most dominant approach to health and illness care (Engel, 2002). The dominance of the biomedical perspective brings with it the process referred to as medicalisation.

The term medicalisation refers to the process where certain everyday bodily and mental phenomena are transferred into the medical sphere (Davis, 1981; Dew & Kirkman, 2002), removing such phenomena from the lay sphere. This means that such phenomena become medically defined problems. It also means that these phenomena are then considered to require medical expertise and intervention (Dew & Kirkman, 2002). An example often given in the literature is that of homosexuality. Dew and Kirkman (2002) discuss the fact that "there have been times when homosexuality has been seen as a sickness and therefore attempts have been made to subject those identified as homosexual to some form of 'therapeutic' intervention" (p. 98). With medicalisation medical professionals and medical intervention become necessary, relevant, and taken for granted. Medical practitioners become recognized as experts regarding diagnosis, treatment, and prevention, and the medical perspective becomes the dominant understanding surrounding matters of the body, health, and illness.

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With relevance to the present study, research and literature has demonstrated how the provision of child health care within New Zealand has not escaped biomedical influence and medicalisation. For instance, it has been revealed how New Zealand parents are exposed to biomedical influence through the Plunket System, which establishes and endorses various biomedical ideas (Beasley, 1996). For example, Beasley argues:

The emphasis on weight gain graphs as tangible evidence of an infant's 'progress' exemplifies a hegemonic biomedical construction of the body and health. The narrow focus on a statistic norm overlooks a wide range of other signs perceived by mothers as equal indicators of their infant's progress. No longer is a mother's assessment of her baby's development considered valid. Instead, it is reconstructed as requiring 'expert' evaluation and transformed into lines on a chart. In other words, infant progress has become medicalised. Failure to conform to the predetermined norm then requires intervention in the form of advice and remedial strategies.

Additionally, in a study investigating how measles vaccination campaigns have been promoted and resisted Dew (1995) argues how childhood disease, such as measles, has become medicalised within New Zealand society through the major institutions of the medical profession and the media. Dew argues that the medicalisation of a childhood disease, such as measles, converts a mild and easily treatable disease into a problem that needs to be dealt with by technical

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means, out of the sphere of the parent. Accompanying this is the transformation of a childhood disease as a social problem into a medical problem. It can be argued that another form of medicalisation within New Zealand is evident with the introduction of the policy for free child health care for children under six. This policy includes the provision of free GP visits – thereby promoting medical care use not health care. In sum, it is within this context of biomedical influence and medicalisation that parents negotiate caring for their child.

In this study, throughout parents' accounts there is evidence that medical thought has a predominant impact or influence upon parents. For example, within their accounts parents frequently draw on biomedical terminology, concepts, and explanations, and often frame medical care use within a biomedical framework of understanding. The influence of medical thought is also reflected in parents' constructions of the child, medicines, doctors, and illness and disease. For example, parental constructions of children as biological entities – with a predominant focus upon the developing immune system – is a reflection of this biomedical influence. With regard to the context of biomedical influence and medicalisation, within which these parents negotiate child medical care use, it is inevitable that such a context is going to have an impact upon them.

The impact of the biomedical perspective and medicalisation upon parents extends to creating a bind for these parents when it comes to negotiating caring

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for their child. This study shows that these parents' construct caring for their child as involving a negotiation (of various issues and concerns) process that takes place within a wider social context that consists of social forces and socially shared ideas of what it is to be a "good parent" and what a "good parent" would do. This is also a social context within which childhood health, illness, and disease are medicalised. This medicalised context, within which parents act, often leads them to experience problems and tension regarding when to take their child to the doctor or have their child immunised. Such tension centers around parental concern for being perceived as neurotic and having bothered the doctor inappropriately while at the same time feeling they must go to the doctor in order to be "good parents". Tension also centers around parental concern regarding receiving judgement or disapproval not only from doctors but also social networks, the parenting community, and the wider community in general.

Altogether this study shows that child medical care use is depicted as a socially based decision-making process that is shaped and constrained by the wider social, medicalised, context within which it takes place. It has been found that parents struggle with the biomedical dominance and hegemony existing within society - negotiating between what is the right thing to do, within a medicalised society, and their own individual concerns and personal autonomy. The result being that parents often felt they have no other option and often excluded other possibilities for managing their child's health and illness. These findings bring to the foreground the importance of the impact of the wider social context and

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biomedicine on parents' perceptions, understandings, and actions surrounding child medical care use. Not only this, but by revealing the importance of this context in shaping and constraining parents' service use this study demonstrates and highlights the importance of recognizing the broader context of this use in understanding parents' decision-making and actions.

As opposed to focusing on discrete variables and adopting a static perspective of child medical care use, this analysis focuses on and explores the pathways and processes involved. In doing so, this study shows that child medical care use is complex and dynamic in nature.

The present study demonstrates how both seeking treatment and utilizing Well Child services occur along a pathway to care that involves parents recognizing illness or being prompted to use services, negotiating various issues surrounding the use of medical care services, and deciding on an action, whether it be seeking medical care or not. This is often a pathway that cycles around with parents reconsidering what action to take particularly if, for example, the child is not getting better or with the ongoing nature of services such as Well Child checks and childhood immunization.

What has also been discovered in this study is that the pathway to care involves two distinct but similar processes regarding seeking treatment for childhood illness and utilizing Well Child services. These two processes both involve the negotiation of various issues and concerns with parents struggling to resolve or

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balance these, in an ongoing nature, in various ways that result in an array of pathways being taken. For example, when seeking treatment parents often struggle with the issue of the risk of antibiotics to the child and how in dealing with this issue parents often attempt to find a balance between the conflicting positive and negative elements of using antibiotics by waiting before seeking treatment. Ultimately, waiting serves as a strategy for finding a balance between conflicting elements, for dealing with tension, conflict, and dilemma surrounding seeking treatment. Additionally, revealing that the use of treatment and prevention oriented services involve two distinct but similar processes adds to the complexity of child medical care use and shows how seeking treatment differs from the use of preventative-oriented services.

Additionally, by exploring medical care use as two different processes this study demonstrates the variability and flexibility of parents' decision-making and medical care use that has remained somewhat untapped in previous research. By looking at the processes involved this project has revealed how parents' decisions are not necessarily made in a deliberative manner. Rather, parents talk of, at times, making informed decisions and weighing up the pros and cons of certain actions - especially with regard to childhood immunisation: at other times, or for other parents, actions may be taken because of a feeling of pressure of obligation as with childhood immunisation.

These findings support research that shows service use does not necessarily involve careful deliberation but is often the result of conforming with others

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(e.g., Hershey, Asch, Thumasathit, Meszaros, & Waters, 1994; Weinstein, 1988). Recent research and theory that have shown how service use is not a static event but involves a process or pathway to care is also supported by the findings in this study (e.g., Cohen, 1995; Cunningham-Burley & Maclean, 1987; Godfrey, 1995; Kaftarian & Safer, 1987-88; Patterson, Freese, & Goldenberg, 1990; Spencer, 1984). In doing so, these findings challenge previous research (e.g., Akesode, 1982; Braunstein, Abanobi, & Goldhagen, 1987; Bukenya & Freeman, 1991; Kemple, 1985; Riley et al., 1993; Stevens, Baker, & Hands, 1986; Turk et al., 1985) that focuses on identifying discrete variables associated with - or that influence - medical care decisions and actions, adopting a relatively static perspective that ignores or downplays the variability and flexibility of parents' decision-making and medical care use, and the possibility of this use as a complex process.

In conclusion, in Chapter Three I argued for the need to adopt a different approach to researching child medical care use that will enable the limitations of previous research to be addressed and, in doing so, will fill the gaps in current understanding in this area. I have developed here a rich understanding that demonstrates how child medical care use takes place not only within the context of - and is shaped by - parents' own understandings, but also within the wider context of various, often conflicting, elements, and how this all forms part of two complex and dynamic processes. However, I do not purport to have solved all the problems evident in previous research in this area. Rather, I have provided here an understanding that reflects an attempt to deal with some

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of these limitations and in doing so contributes to, and furthers, understanding in this area.

### **IMPLICATIONS FOR RESEARCH AND PRACTICE**

The significance of this research lies in the current concern for the status of child health within New Zealand, with a particular focus of concern on the use of available child medical care services. In brief, this study has revealed that child medical service use is a complex process comprising the negotiation of various issues and concerns that arise and are resolved within a particular context. In doing so, the present study is of importance for both researchers and health professionals in the child health area because it provides a basis from which to work at improving appropriate health care use and the status of child health within New Zealand.

In general, the findings from this project demonstrate that despite efforts and interventions, such as free child health care for children under six, and literature and research suggesting the success of these interventions (e.g., Dovey, Morton, & Tilyard, 1999; Newton-Howes, Patel, Frizzell, Luey, & Arms, 1998), parents still talk about various issues and concerns preventing them from using the available medical services. The research approach adopted in this study enabled me to investigate child medical care use in a different manner – one in which I attempted to overcome the limitations of previous research. By

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providing insights into, and an in-depth understanding of, child medical care use, this study provides information from which to develop and refine child health promotion initiatives and policy aimed at encouraging, supporting, and maintaining child health in New Zealand.

In particular, this project reveals how child medical care use takes place amongst various issues concerning the wider context within which utilization takes place. These findings suggest the need for interventions that are focused upon making changes to child medical care services and how they are delivered and promoted, rather than focusing solely upon parental behaviour change. There are several implications arising from these findings consideration of which may help parents in resolving the issues they face or minimize the tension, conflict, and dilemma surrounding these, and in doing so, foster better service use.

To begin with, this research has shown that the appropriate use of child medical services is an important issue for these parents, particularly with regard to how they (the parents) will be perceived by doctors. This issue is infused with tension, conflict, and dilemma that impacts upon parents' actions - often leading them to delay taking an ill child to the doctor. In terms of educating parents, providing information on when to seek help from a doctor - such as symptom lists - is one way of fostering and encouraging appropriate service use. However, the findings from this study show, consistent with Spencer's (1984) argument, that although such information may be useful for parents it

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may also be counter-productive and foster tension and conflict for parents in terms of when to take a child to the doctor. As a result, improved service use may not be achieved. This suggests that a different approach needs to be taken to foster appropriate medical service use. Such an approach can be found by taking a closer look at the findings from this study.

The findings in this study show how child medical care use occurs within a particular context in which the biomedical perspective is predominant - bringing with it medicalisation. In particular, it has been shown how this context (and the hegemony that exists within it) creates a bind for these parents. That is, this context often leads parents to experience problems and tension regarding seeking care from the doctor (including immunization advice). As mentioned earlier, such tension centers around socially shared ideas of what it is to be a "good parent" that clash with individual concerns. This means that for these parents they are not only concerned for the health of their child but they are also concerned with the wider implications of their actions.

A move forward may be achieved by recognizing the complex social, medicalised, context within which child medical care use takes place and by considering the implicit assumptions underlying child health promotion and medical care. From here the findings reported in this study can help health promoters assess the types of campaigns or messages that will be most valuable in not only promoting effective medical care use but also child health care use and child health in general.

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Another move forward would be for health professionals to recognize and take into account the findings of this study when offering treatment and advice to parents. Health professionals need to be aware that they are in a power relationship and they need to carefully consider the impact their interaction with parents can have on the confidence, decisions, and actions of parents. As suggested not only by this study but also by previous research (e.g., Cunningham-Burley & Irvine, 1987; Spencer, 1984), in fostering the use of medical services it appears that an important area to focus on is not only alerting doctors to the issues and concerns parents face in seeking care, and how they are dealt with, but also the manner in which doctors communicate and deal with, or relate to, parents. By failing to listen to parents, ignoring or dismissing parents' illness assessment of their child, or judging and treating their concerns as trivial and time wasting, there is the possible danger of doctors' fostering tension or conflict for parents in care-seeking, particularly in times of uncertainty.

Within psychology there is a substantial amount of literature and research on the doctor-patient relationship. This literature reveals various models of this relationship that vary along a continuum between a paternalistic model and an informed-decision-making model (Benbassat, Pilpel, & Tidhar, 1998; Goodyear-Smith & Buetow, 2001). Within the paternalistic model the doctor makes the decisions without patient input. This model emphasizes doctors' authority. Alternatively, within the informed-decision-making model doctors provide

information and advice and the patient or 'consumer' makes the decisions. This model emphasizes the patient's autonomy.

Research investigating doctor-patient relationships within New Zealand has provided evidence of a paternalistic relationship between doctors and parents (Buchanan, 1991). This research found that parents felt there was a lack of information given by doctors regarding the side-effects of medication and instructions on what to do if the medication caused problems. Buchanan (1991) suggested "this may be a continuation of the paternalistic attitude where the doctor knows best; and information that may affect patients' decisions about giving the medication to their children may be withheld" (pg. 93-94). Buchanan (1991) also states that although efforts have been made to provide patients with more information a divide still exists between patients and doctors that will be difficult to close.

The preferred model of the doctor-patient relationship is one in which there is shared responsibility, mutual dignity and respect, and a balance of power between the doctor and the patient (Friedman & DiMatteo, 1990). Within this relationship the patient is fully informed and their input is sought in medical decision-making. Goodyear-Smith and Buetow (2001) argue that by developing and building on a mutually respecting partnership that involves negotiated care paternalism can be resolved. It has been found that having the patient and doctor work together as a team, with the doctor acknowledging the information

or expertise patients bring to the relationship, is the most effective approach regarding patient co-operation and health (Friedman & DiMatteo, 1990).

Altogether, this supports the argument that efforts need to be made by health professionals to facilitate a shift towards a balance in power between doctors and parents. Doing so has the potential of reducing the tension and conflict parents often experience in decision-making surrounding seeking child medical care. I have emphasized the word "balance" here because in making this argument I also acknowledge that too much of a shift in power or a disempowerment of health professionals can prove disadvantageous. Goodyear-Smith and Buetow (2001) warn that doctors need to maintain a certain amount of power to maintain professional integrity and that disempowering doctors may lead to the erosion of patient trust and faith. This means that great care must be taken in creating a balance in power between doctors and parents.

This study also reveals that when some parents are unsure of whether to go to the doctor they often turn to family and friends, nurses, and pharmacists as referral agents for the doctor. This suggests that another way of dealing with the issue of when to take an ill child to the doctor is to focus efforts on raising awareness of the role of nurses and pharmacists as advisers and referral agents for the doctor, emphasising the skills and information that they can provide. This widens the health network for parents and may relieve the tension parents experience in deciding whether or not to take an ill child to the doctor.

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However, it could be argued that raising the profile of these services will not address the problem of access to these services for parents nor the problem of funding these services as their demand increases.

An alternative approach that is currently in action is a nationwide Healthline service that aims to promote good health and well-being among New Zealanders by facilitating appropriate healthcare use (MOH, 2002). Healthline is an initiative, supported by the Ministry of Health, that provides a free telephone health advice line 24 hours a day seven days a week (MOH, 2002). The knowledge and skills of registered nurses are employed to guide people to the most appropriate form of care. An evaluation of the Healthline service found that it provides a safe and effective way of directing New Zealanders to the right care, at the right place, at the right time (Kalafatelis, Fryer, Harsant, Cunningham, & Taite, 2002). It has also been found to overcome problems of access to health services (e.g., during out-of-hours) and provides a cost-effective approach that reduces unnecessary demands on other health services by directing the public to a more appropriate response. When considering the findings in this study, such an initiative may prove invaluable in reducing the tension parents experience in times of uncertainty and aid them in their decision-making.

Finally, with regard to developing initiatives promoting the adoption of child medical care services such as childhood immunisation, caution needs to be taken in the development of such initiatives and campaigns and the manner in

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which education or health messages are delivered. This study shows that parents are not necessarily persuaded by health messages, that there is some resistance among parents to the views of medical science, and that there is often a feeling of obligation or pressure to conform to social expectations surrounding the adoption or rejection of medical care services. This suggests, consistent with Greenough's (1995) arguments, that care needs to be taken that strategies for promoting medical care use and health professionals do not come across as coercive or intimidating as this may foster resentment towards health professionals and the medical profession. Further, the findings suggest that care needs to be taken with initiatives such as mandatory choice (where parents must state whether their children have been immunised or not before they enter day-care and school) so as not to foster discrimination among parents and a feeling of pressure. Rather, these initiatives need to be developed in a manner that fosters a supportive environment in which parents can make an informed choice.

### **MOVING FORWARD: FUTURE RESEARCH DIRECTIONS**

Although the aim of this research was to attempt to fill the gaps in current understanding in child medical care use there are a number of limitations within this project that should be acknowledged. While the present study has delved into and explicated the processes of utilising these services, at various points throughout this thesis the discussion has touched on issues and topics

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beyond the scope and design of the present investigation. These issues and topics provide ideas for future research investigations that could extend the area and understanding of child medical care use.

The focus for this study has been on parental talk about seeking and utilising professional child medical care services for the treatment and prevention of childhood illness and disease. As mentioned earlier, when a child becomes ill or when a parent is prompted to consider preventative measures against childhood disease there are various pathways he or she may take in terms of dealing with these issues. Medical care services available to parents in New Zealand extend beyond those focused on within this study, for example, they include nurses, pharmacists, a telephone helpline provided by Plunket, and alternative health practitioners. Further, there is also the management of the ill child and illness and disease prevention in the home with, for example, diet. I went into this study with the aim of developing a dense and complex understanding of child health care that was wide-ranging and broad-based encompassing and following all of these pathways. As the data analysis process progressed the focus was directed on seeking treatment for childhood illness from the doctor, the adoption of childhood immunisation, and utilising Plunket Well Child checks. Although the existence of these other pathways was acknowledged within this investigation, their use was found to be a subsidiary part of the process surrounding seeking treatment from the doctor, adopting childhood immunisation, and utilising Plunket Well Child checks. As a result, no further efforts were made to delve into the use of these other

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services or the home management of child health, but rather the focus was directed to this particular medical aspect of managing childhood illness and child health. This specific focus provided an in-depth and rich understanding of the process of seeking medical treatment from the doctor, attending Well Child checks, and adopting childhood immunisation that revealed these processes to be substantially complex. However, the key point here is that the complexity of child health and illness care extends beyond the findings in this investigation and should be explored further.

Along a similar line of argument, the focus for this investigation was on treatment-seeking for everyday childhood illness and for the prevention of disease. Caring for child health encompasses more than caring for childhood illness and disease. Other medical care services available to parents include dental services and speciality services for chronic illness. These services are also an important aspect of child health and are worthy of investigation. Such an investigation calls for larger scale research to explore the range of services available and to take a wider approach by looking not only at childhood illness and disease but, for example, at accidents and chronic illness and chronic disease. Such research could explore the complexities involved in the use of these services and develop further understanding of child medical care use. Information revealed by such an investigation could provide answers to questions such as “Does the process of seeking help for childhood accidents differ from the process developed in the present study, and if so how?” Overall, although the specific focus taken in this study provides an in-depth

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and rich understanding of child medical care use surrounding everyday childhood illness and disease, this topic is extremely broad, extending beyond the perimeters of this study, and should be explored further.

New Zealand society comprises diverse ethnic groups, including Maori, Tongan, Samoan, Cook Islands, Asian, and Pakeha, with differential child health care practices, including medical care use, between groups (e.g., Department of Maori and Pacific Health, 1999). The parents who took part in this research shared similar cultural characteristics in that they were all of European origin or descent. For this study I adopted an open process of soliciting participants with the aim of obtaining a broad range of parents. Unfortunately, parents of other cultures did not volunteer to take part in this study. During the process of coding and categorising the data I sampled for more parents, but again I had no success in recruiting parents from other cultures.

The importance of researching parents of different ethnicities lies in recent research within New Zealand. Such research has shown that Maori and Pacific Island children have worse health than non-Maori or non-Pacific Island children (e.g., MOH, 1997a, 1999a). To begin with, Maori children are hospitalised at higher rates than non-Maori children for most of the major causes of hospitalisation, which include respiratory conditions and infectious diseases (MOH, 1999a). Pacific Island children are also reported to have substantially higher hospital admission rates for respiratory illness compared to

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national rates for children under five (MOH, 1997a). From 1992 to 1995 Pacific Island children aged 5-9 years were also reported to have higher rates of acute rheumatic fever than other children and to have a hospitalisation rate for pneumonia that was twice the rate of other children this age (MOH, 1997a). The rates of a number of communicable diseases are also reported to be higher among Maori and Pacific children (MOH, 1999a). Additionally, a study into infant care practices in New Zealand that included an element of medical care seeking among Maori, Tongan, Samoan, Cook Islands, Niuean, and Pakeha communities found broad ranging similarities and contrasts across the different cultures regarding infant care practices (Department of Maori and Pacific Health, 1999).

Further, recent research within New Zealand (The Department of Maori and Pacific Health, 1999) has revealed clear differences between various ethnic groups (including Maori, Tongan, Samoan, Cook Islands, Niuean and Pakeha) of parents regarding infant care practices. For example, female whanau members are an important element of the care of infants of some Maori parents. Such research is supported by other studies that have shown how for the Polynesian culture, in comparison to European Pakehas, factors such as the extended family are of particular importance when it comes to health care (Ma'ai'i, 1986). Additionally, research by Laing and Miteara (1994) has shown how the Samoan and Cook Islander's concept of health, life and illness impacts on their use of Western health care services. This research also shows how the extended family is involved in the decision-making process surrounding the

use of Western medicine. Overall, such research indicates that for Maori and Pacific Island people the issues surrounding the use of Western health care and medicine not only differ to other cultures but that they are also complex. It is argued that a better understanding of Maori and Pacific Islander's concepts and understandings surrounding health and medical care use is needed in order to improve upon their standard of health. Had parents of various cultural groups taken part in the current study such a perspective could have been obtained and possibly different pictures of the process of child medical care use may have emerged. For instance it may be that the various issues raised by the parents in this study, for example the debate on whether to immunize or not to immunize a child, may not be reflective or even relevant to other groups of parents.

Altogether this research demonstrates the need for a broader investigation that allows for the inclusion or investigation of not only Pakeha parents but also those from other cultural or ethnic groups such as Maori, Tongan, Samoan, and Asian immigrant populations of parents. Of particular value would be to conduct an examination that compares and contrasts the process of utilising child medical care services and the constructions surrounding this process among the different cultural groups to find out the answers to questions such as "Is there a construction of the good parent among Samoan and Tongan parents?" "Does this concept of a good parent play a significant role in their medical care use?" Overall, there is much to be gained from future research that focuses upon various cultural or ethnic groups.

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Finally, it must be emphasised that child medical care use takes place in a context within which these parents seek out - and are exposed to - information on child health and illness, and the available child medical care services. In particular, such information is available to parents through, for example, health professionals, popular texts, and health messages in the media. This suggests that another area worthy of investigation is to explore these information sources for the dominant constructions portrayed within them and to compare these findings with those of the present study to extend the analysis with parents. For example, the findings from the present study raise a number of important questions that provide a basis for further investigation in this area regarding the good parent construction, such as “Is this construction shared with health professionals such as doctors and Plunket nurses?” “Is there a good parent construction evident in educational programmes and material, popular texts on parenting, health campaigns and health information available for parents?” “How do these constructions relate to or differ from those of parents?”

Overall, while there are a number of limitations apparent within this study that point to further areas for investigation, this study has made a substantial contribution to our understanding of child medical care use. In particular, insights have been provided which reveal that such medical care use is a complex process consisting of multiple elements that extend previous research and contribute to understanding in this area. In doing so, this study provides an understanding from which to develop and refine child health promotion

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initiatives and policy aimed at fostering better child health within New Zealand.

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**APPENDIX A**

**Invitation Letter**

**PATHWAYS TO THE DOCTOR**

I am conducting a study aimed at exploring the views and experiences of child-carers regarding the management of child health and illness and the processes through which they make the decision to seek prevention and treatment for childhood illness and disease. The study is being conducted as part of my Doctoral Degree at Massey University and I need some people to volunteer to take part.

Volunteers need:

- \* to be parents or guardians (including those who are single or married)
- \* to have at least one preschool child (aged between 0-5 years)

An information sheet is enclosed detailing what the study involves and your rights should you wish to take part.

If you are willing to take part or wish to know more about the study please write your name and phone number in the space provided and send this letter back to me in the free-post envelope provided. I will then contact you to discuss the study further and to arrange a time and place for an interview.

Your assistance in this research would be greatly appreciated.

Name: .....

Phone Number: .....

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**APPENDIX B**  
**Information Sheet**

**PATHWAYS TO THE DOCTOR  
INFORMATION SHEET**

**What is the study about?**

The aim of the study is to explore the views and experiences of child-carers regarding the management of child health and illness and the processes through which they seek prevention and treatment for childhood illness. The research is being done as requirement for a Doctorate. The study is being jointly run by Mr Kerry Chamberlain, a Senior Lecturer, Dr Christine Stephens, a Lecturer, and Melanie Martin, a Doctoral student. This research is funded by the Health Research Council of New Zealand.

**What would I have to do?**

If you are willing to take part, all you need to do is participate in an interview. You will be asked to talk about your views and experiences regarding childhood health and illness, the strategies you use to manage child health and illness, and how you seek prevention and treatment for childhood illness. I will also ask you for some background information such as the size and composition of your family and health practices within your household. The interview will take between 45 to 60 minutes and will be audio taped.

If you agree to take part in the study, you have the right to:

- decline to participate.
- refuse to answer any particular questions.
- ask for the tape recorder to be turned off at any time during the interview.
- withdraw from the study at any time.
- ask any questions about the study at any time during participation.
- provide information on the understanding that your name will not be used unless you give permission to the researcher. All records will be identified only by code, and the relation between your name and code number will be known only to the researchers. Interview tapes and transcripts will be stored in a secured area and will only be available to the researchers. Brief quotes may be used in reports and publications that are prepared about the study but it will not be possible for you to be identified. The transcriber of the interview material will sign a confidentiality agreement. The audio tapes will either be returned to you or disposed of at the completion of the study, as requested on the consent form.

- be given access to a summary of the findings of the study when it is concluded. These will be posted to you on request.

You are welcome to contact any of the following people, either before you decide to take part or at any time during the study, for further information or to clarify any questions you may have about the study:

Melanie Martin, School of Psychology, Massey University, telephone 350 4147

Kerry Chamberlain, School of Psychology, Massey University, telephone 350 4123

Christine Stephens, School of Psychology, Massey University, telephone 350 4146

**APPENDIX C**

**Consent Form**

**PATHWAYS TO THE DOCTOR  
CONSENT FORM**

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand that I agree to participate and I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researchers on the understanding that my name will not be used without my permission and that the information will be used only for this research and reports and publications arising from this research project.

I agree/do not agree to the interview being audio taped. I understand that direct quotations from the interview may be used in reports about the study but I will not be able to be identified.

I also understand that I have the right to ask for the audio tape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

Please tick one:

..... I would like to have the interview tape and transcript returned to me at the completion of the study.

..... I agree to have the interview tape and transcript destroyed at the completion of the study.

**Signed:** .....

**Name:** .....

**Date:** .....