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Conference paper

Ethnography and the ethics of care

Observing standards of 'goodness' set up in the everyday care practices of changing Finnish maternity health care

Introduction

I will start off my paper with a snapshot from my ethnographical data. In it I will contrast two ways of attributing qualities to the unborn as I have gotten to know them during my fieldwork at 3 different maternity health care[1] clinics in one large city in Finland

> *Often before the screening the public health nurses choose to inform pregnant women and their partners about screenings in accordance with the brochures handed out at the clinics. This seems to be in accordance with the local policy linked up with the individual will: women need to make a choice between attending the screenings and not attending. Furthermore, the nurses use rather*

[1] Finnish maternity and child health care clinics are organized within public health centers, run by public health care nurses and intended to ensure a good standard of health for the mother, the unborn child, the infant and 'the family as a whole'. Its services are provided free of charge, and as such, the provision of care indicates that health services for pregnant women have become a state responsibility – as part of the Finnish welfare society system.

clinical and medical terms when referring to the unborn and try to keep to 'the facts' . This is something that is done on purpose: nurses tell me that they intentionally use the term 'fetus' and try not to personalize it in other ways before the screenings to ease the anxieties some women might have concerning the screenings. However, nurses offer these 'facts' in various ways embedded in advice giving on how to think positively, in encouragement and consolidation. They may, for instance, tell stories of their own pregnancies and give the pregnant woman a warm hug. When discussing the screenings afterwards, mostly in the cases where there are no abnormalities, the nurses go back to talking about babies or 'womblings' (kohtulainen) that 'do' things and are new members of the family in many ways. They may have a nose that looks like their fathers' in the ultrasound screen, or they may show temperament if they kick a lot in the womb. It seems that these associations and positive feelings toward the baby-to-be are provoked by the nurses.

It is not really surprising that health workers push themselves back and adhere to giving 'neutral' information like this about screening for somatic abnormalities when it comes to making decisions about diagnostic tools or treatment. The highly valued Western ideal of patient (informed) choice or autonomy in its varities obviously alters daily care at the maternity health care clinics, and most often the debates around reproductive issues are organized in terms of citizen/social rights of some kind (e.g. Helen 1997; Pulkkinen 1998, Mol 2002; 2008; Duden 1993). Thus, the activities here and more generally at the clinics, are often coordinated and framed by medical ethical repertoire in alliance with the biomedical knowledge about the natural process of things.[2] Patient autonomy is taken as a self-evident 'good' within this repertoire of care.

Currently there are two major ways of assessing the 'goods' of patient autonomy: professional and ethical. In the professional approach the dominant mode is doing research on the efficiency of care in accordance with the standards first set for the care. In ethics, instead, the prevailing style is to judge decisions by weighing arguments for and against them. Ultimately, both of the discourses try to answer the question of who is in a position to decide what counts as 'good'. When 'patients'/'clients' are put in this position of making decisions, this is usually done either in the way of the market or in the way of

[2] This is furthermore entangled with population policy anxieties in that information given in the leaflets is aimed at improving the health of population, even if it is the individual (citizen) who is suppose to act (for the common good). Surely ethical and medical reasoning may also contradict like in debates about ability to articulate will.

the civil society. In the former way of living out a right to choose patients become customers who need to make value choices between different 'goods' of health care i.e. care acts and interventions. In the latter, instead, what is chosen is not interventions as 'goods' but as policy measures. Patients act first and for most as citizens who are granted jurisdiction and representation over interventions, but they must argue civicly. (Mol 2002, 166-167; 2008, 14-42; Harbers & Mol & Stollmeyer 2002, 217-219.)

Yet, this is not the end of the story. *The ethics of care* has for few decades now amended the way 'will' or 'choice' is understood in ethics. A critique of Kantian, utilitarian and liberal conceptions of the autonomous subject who makes rational choices was actually the starting point for ethics of care. (e.g. Held 2006, 3-4; Baier 1994.) This has meant a shift from universal principle of doing 'good' to practical deliberations on various available courses of action in *specific* situations, and a shift from autonomous (human) subjects to relational (human) subjects. By doing this ethics of care has tried to grasp the fact that power differences alter the possibilities of 'doing good. (Harbers & Mol & Stollmeyer 2002, 218; Mol 2008; Held 2006)

However, so far the ethics of care has been dominated by humanist orientation to practices: human beings are the relevant actors in its conceptualizations (Harbers & Mol & Stollmeyer 2002, 218). It has been noted that to understand clinical practice it's not only the concept of will or choice that needs to be altered but also the understandings of the workings of nature and technology, the materialities and technicalities of practices, need re-addressing (ibid., Mol 2002; 2008). Such work of re-addressing has been only recently attended to by mostly science and technology studies (STS) scholars, such as Annemarie Mol (2002; 2008), Hans Harbers and Alice Stollmeyer (in Harbers & Mol & Stollmeyer 2002).[3]

[3] In this tradition 'care' includes 'cure'. Cure that is often associated with knowledge-intensive and technology-depended is seen as form of care. Just as the activities of care that are often associated with nurses, the activities of cure that are often associated with doctors, make life more bearable. First of all, in practice, they overlap. For instance, caring advice may help healing. Furthermore, pregnancy as a medical condition is not something that leads to recovery, and in pregnancy there may be complications that can not be cured. (Mol 2008, 1-5)

In the specific case of screenings this means that the 'natural course' of fetal development or pregnancy is left unexamined in a way. If the fate brought on by nature is invoked, what is left unaddressed is the fact that people experience and deal with fetal abnormalities and uncertainty in different ways. Some women's anxieties may be addressed by offering support - advice, encouragement and consolidation - while others' may not. It does make a difference *how* doubt that is just as characteristic to health care practices as is certainty is lived with. For instance, shifting repertoire from unborns with social relations and identity to unborns closer to mere bodies in a natural process can be understood as a way of attuning to the unpredictability of screening results. Concept of nature does not hold a lot of explanatory power when considering the question of 'how to give shape' to the course of pregnancy (cf. Mol Harbers & Mol & Stollmeyer 2002, 218).

How, then, can *good* shape be given to the course of pregnancy, if pregnancy matters and the unborn are in this way not one but multiple, and health care practice attends to this multiplicity and uncertainty? Surely, the fact that activities at the clinics do not actually depend so much on what is 'real' in a singular and straightforward way, and that professionals orient themselves toward ideal standards, such as 'patient autonomy', 'health' and 'the good life', in many differing ways, does not mean that we can not seek for positive interventions. This is where ethnography as a methodology of inquiry comes to the center of stage.

Engaging in an ethnography of practicalities and materialities of daily care allows attending to the 'goodness' of care in a different way than for example in the medical professional or ethical approaches. It sets out to enquire the modes and styles of setting up standards in care work *practices*, and to study giving 'good' or avoiding 'bad' care (Mol 2008). Thus, the interest is in knowledge practices, but not so much in finding 'the truth' but in how objects, such as pregnancy matters, are handled in practices. Since they are not same from site to site or moment to moment, this ethnography also asks how the coordination between such objects proceeds[4]. (Mol 2002, 5-6.) Answering these

[4] They may be in tension, but all the same depend on one another (Mol 2002, 5-6)

questions involves paying attention to specific issues that are at stake in practices. Also, since this approach claims that passing judgement in a single difficult moment of deciding about the course of action does not really tell a whole lot about the 'goodness' of care, it calls for an ethnographic time frame. A long time period of fieldwork is required to attend to entire trajectory of care for patients/clients. Overall, because the issue is to explore the modes of care given at specific and particular places, such as clinics, and dynamics of a collective that insists on social-materiality of practices, ethnography offers a suitable tool kit. (Mol 2008; Harbers & Mol & Stollmeyer 2002; see also Beaulieu & Scharnhorst & Wouters 2007; Hine 2007; Clifford & Marcus 1986.)

The purpose of my paper is to further discuss ethnography and ethics of care in the context of Finnish maternity and child health care system (MCH) that is undergoing a vast organizational change. The changes stem from challenging prevailing policy guidelines, and various interventions have been developed and implemented in an effort to bring about change in the existing work practices of MCH during last about 10 years. In the new policy standards care is to be directed to the social unit of 'the family' to prevent future problems (Rimpelä 2008; Viitala et al. 2008). Furthermore, increased emphasis has been laid on the benefits of multi-professional team work among professionals from different fields of social and health care (e.g. Winthereik 2008; Kangaspunta et al. 2005).

This paper examines the various ways in which the idea of a family-oriented and multi-professional care is realized in the work practices of MCH by focusing on one specific intervention, the so called *family-oriented MCH clinic*. I follow the task set up by Mol (2002; 2008) and Harbers, Mol and Stollmeyer (2002) by asking which standards are set up in the day to day care practices of caring with the implementation of this new intervention? What 'goods' are striven after in practice? What 'bads' are avoided? And for the sake of whom and for what?

My paper is structured as follows: First I will give a little background to my case, the changing care practices of Finnish maternity health care. Then I will move on to briefly address my particular ethnographic orientation and its theoretical and methodological

commitments. After that I shall attend to all the different sites of 'doing' pregnancy and 'good(s)' in the clinical practice of new working methods that the family-oriented MHC clinic has entailed for maternity health care. In the concluding part, in addition to drawing together my results, I will return to the question of what (my) ethnographic approach allows me to see that other methodology might not.

The Finnish maternity health care in transition

The new Finnish policy guide-lines suggest that instead of focusing on medical screening and children already born, care work should direct attention to the social and psychological environment of the child(-to-be), in this case the collective of "the family", to prevent future problems (Rimpelä 2008, Viitala et al. 2008). Furthermore, the family should be participating as an equal partner to the health care professionals in enhancing child health, development and family welfare.[5] These developments in Finland can be associated with the idea of *shared care* that is widely advocated in the health and social care of many Western countries. The concept is used to designate systems of health and social care in which lay people are involved in taking responsibility and making decisions concerning their health and social circumstances, and/or their health and social care is shared amongst various professionals (see e.g. Boyle et al. 2003; Winthereik 2008).

The emphasis on the MCH system and the argumentation for reform outlined above stems from two particular observations made by different national and municipal policy actors. First of all, many commentators have noted that mental health, social and developmental problems are increasing among young children and accumulating in disadvantaged families (Stakes 2006, 2007; Rimpelä 2008). Secondly, early family relations are seen as crucial in contributing to child well-being, mental health and development (Goodman, 2008; Swanson, & Wadhwa, 2008).[6] This indicates that families need support especially in the critical stage of transition to parenthood. In Finland MCH

[5] This participation of families is often discussed in terms of "family-oriented work" (fieldnotes 2006-2008; Kangaspunta et al. 2005).

[6] It is important to note that none of these worries or commitments are totally new; some of them date back to the 1960s (see e.g. Kuronen 1994; 1999; Nätkin 2003, 19-20; Helén 1997, 11).

clinics have played a major role in offering such support as they reach almost 99% of the population (Viitala et al. 2008).

Various interventions have been developed and implemented in an effort to bring about change in the existing work practices of the MCH (Kangaspunta et al. 2005; Viitala et al. 2008). One such intervention is the so-called *Family-oriented MCH clinic* in one large city in Finland[7]. This is the model that I am investigating at a practical level and in it the changes that the MCH system has been subjected to include: 1) the integration of the so-far separate clinics for maternity and child health care[8]; 2) the utilization of the expertise of multi-professional teams in solving the problems of families. This involves pooling together experts from the fields of early social and health care of children[9], and 3) new working methods for public health nurses and midwives to focus on psycho-social

[7] The intervention in question and its implementation was a result of two different projects. It was first piloted within the municipally funded 'Basic service team and family's maternity and child health care clinic project', which was part of a larger mental health project in the municipal in 2002-2004. The dissemination of this interventionist model was first carried out in the 'Welfare from maternity and child health care clinics' project (*Hyvinvointia neuvolasta –projekti*) which is a subproject of a nationally funded PERHE-project (*PERHE-hanke*) in 2005-2007. The intervention model is to be applied to all child and maternity health care clinics by the end of 2011 as a municipal project.

[8] Because my focus is in maternity health care, I will not attend to the practice of combining maternity and health care.

[9] In general, social and health care work are often described in terms of multi-professionalism nowadays. In a nutshell this refers to work which combines knowledge systems and expertise of more than one field. It aims at a more 'holistic' understanding of an individual family's situation and overcoming administrative and organizational boundaries. (Kangaspunta et al. 2005; Kangaspunta & Värri 2007; Hyvinvointineuvolan kehittämistavoitteet 2007; see also Vuori & Nätkin 2007, 7.) In the case of the clinics where I did my fieldwork, the professionals included in the team were 2 public health nurses, two family workers, a social worker, 2 physicians, and a maternity and child health care psychologist. Team work is carried out at the clinics in meetings that take place about every 2 weeks. The nurses bring cases to discuss about to the meetings, and they also invite the individual families with problematic situations to come to the meetings. At the meetings further action is negotiated.

support[10], through methods such as interviewing with and without forms ('welfare assessment forms)[11], and conducting home visits during late term pregnancy[12].

Institutional ethnography and socio-material practices

My theoretical and methodological orientation combines institutional ethnography (IE) as theorized by Dorothy E. Smith (e.g. 1987; 2005), and draws on insights from writers associated with a new generation of science and technology studies that focus on differences within medicine and between medicine and other locations when exploring how health, bodies and "conditions" (or disease) are politically and discursively produced in medical practice (e.g. Mol 2002; 2008; Harbers, Mol & Stollmeyer 2002; Haraway 1991; 1996; Berg & Mol 1998). These writers have also been characterized as engaging in *studies of technoscience*.

Smith's conceptual 'design for ethnography' works for me as a broad frame for conceptualizing how institutions exist as the object of inquiry (Smith 1987; 2005). In short, the overall project of institutional ethnography is to explore the social relations organizing institutions as people participate in them, from the perspective of specific groups within such institutions. My particular focus is on pregnant woman's partial and shared agency and embodiment. In other words, the actualities of pregnant woman's lives and accounts of their experiences of it work as an entry-point (*standpoint*) that organizes my analysis. It is, then, from this partial and particular perspective that the analysis

[10] The concept of 'psycho-social support' derives from a wide variety of traditions of psychological theory and is widely used in approaches to health care and social work (Vuori 2001; Eräranta 2007, 83). This is the term that was mobilized to direct care work toward the 'social and psychological environment and welfare of the child(to-be). Orientation around psychosocial welfare is seen as addressing issues such as anxiety (Castaneda, McCandless, & Palermo, 1956), self-esteem (Rosenberg, 1979), family relationships, and social support (Punamäki 1996, 3). When this concept is employed with reference to maternity health care, new (sub)categories emerge. Factors which are seen as crucial in indicating the need for support are identified in families' social relationships including: problems within the woman's relationship to her partner, anxiety levels, use of intoxicants, the family's financial situation, and mental images of the child-to-be (e.g. Kangaspunta et al. 2004; 2005; Field notes from the health nurses' training in the spring of 2007). (See also Vuori & Nätkin 2007)

[11] The word 'form' could be substituted for the word 'questionnaire', because in Finnish language and in the institutional practice considered here they are the same.

[12] In addition to home visits conducted immediately after birth.

proceeds to account for the 'ruling relations' coordinating the work and workings of all the actors involved at different levels (or as broadened, sites) of institutional activities.

Influenced by specific writers (e.g. Mol 2002; 2008; Harbers, Mol & Stollmeyer 2002; Haraway 1991; 1996; Berg & Mol 1998) in the field STS or technoscience studies I analyze the socio-material or 'material semiotic' ways of producing knowledge. Furthermore, in drawing attention to material semiotic enactments, these researchers mobilize an enlarged conception of agency, extending and broadening it to include non-human actors and objects.

For a long time I was stuck in a search for a singular over-determining and subjugating logic that organizes agency and activities at the clinics. In this pursuit I missed the health care practices that are not (only) organized in terms of some unificatory power, such as that of medicine as a body of knowledge (see also Mol 2002, 62-71 on the problems of Faucauldian studies). I share the perception that (medical) science does not have the power to impose its singular order on any social world (e.g. Latour 1988, 178; Mol 2002, 62; 2008). By acknowledging that there are multiple and related ordering logics at play in institutional practices, I can start to see that in different relations to fulfilling for instance commitments for care work to do for example formal (computerized) assessments and giving standardized advice and information there is also less rationalized and practical logics to the care practices of Family-oriented MCH.

This multiple 'logic of care' (Mol 2008), and thus agency, that is best understood in terms of moment to moment practical, material and situated practices that produce different kinds of subjects, persons and objects – *enacted* in a distributed and partial way in different locations of maternity care. This is also the way I will study care practices, and these conceptualizations of care and care activities allow me to investigate the multiple ways that different agencies, be they 'clients', 'professionals' or babies(to-be), matters of concern in pregnancy are done in different ways at the appointments, decision-making team meetings, home visits and so on. This, then, allows me to also address the

question of ‘godnesses’ in care: how are the situations of people coming to the clinics improved? What is ‘improved‘ in each specific place and time?

In other words, care work is working with differences, and agency is first and foremost, to be found in relations or sets of relations that are enacted in the everyday organizational activities. Furthermore, the term ‘enacting’ leaves open who or what an actor is. Many non-solid entities are involved in enacting health, diseases and bodies. By leaving open the who and what does the doing we can study human and non-human participants as done in similar ways in practice, without getting tangled in presumptions concerning foundational differences between (human) subjects and (non-human) objects incorporated with modernist ontologies about agency.[13] (e.g. Mol 2002; 2008.) Things and not-yet-humans can also work and do things.

The primary data analyzed in this paper, consists of 13 partially transcribed video tapes[14] deriving from recordings during multi-professional team meetings and 9 transcribed video tapes deriving from recordings during ‘welfare assessment’ interviews, and of field notes based on observations at three different maternity health care clinics and health care nurses’ training events in a one large city in Finland. Reference will also be made to the records of 40 maternity health care appointments, to transcripts from interviews with pregnant women's and maternity health care health nurses' (7+7), as well as to collected guides and handouts distributed to families, forms on pregnancies kept by health nurses

[13] The divide between object and subject is dissolved. We need to give up perspectivalism that is interested in how, for instance, medicine knows and perceives its objects, along with it the idea of active (knowing) subjects and passive objects (known) (e.g. Mol 2002; 2008).

[14] The choice to use videotapes was originally made for quite practical reasons. I have collected my data as part of a larger research project, ‘The family as client in maternity and child health care: Team-work and psycho-social orientation in supporting transition to parenthood’. The other researchers’ methodological orientation is towards conversation analysis, and, hence, they use video tapes as their main form of data. Since I saw no big problems in using videotapes as a source my data, it was then decided that the appointments and team meetings would be video recorded without a researcher present in the room. Although the use of, video taping is not common in ethnographic fieldwork, I don’t see it as a very problematic method. In fact, the video tapes worked as a sort of a memory aid for me: I can always go back to them and, thus, to the detailed recordings of happenings at the appointments, in a ways that mere memory and field notes do not allow. Surely, there are methodological consequences in having a camera present at an appointment or a team meeting than a person observing. For instance, a camera has a limited scope of the environment than a observer has, and a camera is a different kind of a co-producer of knowledge than a observer is in each given situation.

and local and nation-wide guide-line material for and research on care work. The fieldwork and the assembly of these materials was undertaken over a three month period in the course of 2006–2008.

According to my methodological orientation I have teased out and listed the enactments of pregnancy as a matter of concern and the sites of those enactments in my fieldwork material. That is, I have explored these multiple 'objects' done differently in screening of disease/problems, treatment and research in pregnancy. This has also involved analyzing who or what does the enacting in a given site. After differentiating between the enactments and their spatial specification I will map the ways in which these multiple objects are related to each owns varieties, i.e. how are they coordinated. In other words, the aim is to show how, with all the different enactments, friction and difference in medical practices, at the end each and every pregnant woman is supplied with, if not a single diagnoses or assessment, at least a single treatment or the decision not to treat. Object may be done multiple in a given institution, but it is not fragmented, 'it hangs together' (Mol, 2008).

Addressing this 'hanging together' is also attending to the organization of Finnish maternity health care as it is today in that whichever enactment wins the day is embedded in 'ruling relations' that are articulated in everyday practices (cf. Smith 1987; 2005). So finally, I will think through, how all this coordination of work relates to overall organization of MCH, and the 'goods' it might entail.

Different sites of 'doing good'

My ethnographical approach is 'multi-sited'. This does not merely refer to the fact that I have multiple and complementary research material, although I do believe that such a rich and diverse data does help me to better address the many places of doing maternity health care. Moreover, the multi-sitedness, here, refers to the way I conceptualize the activities taking place in the maternity health care organization: the activities of doing protocol, doing different kinds of clinical work, research and so on. They may or may not

involve ‘doing good’, and, yet, they only exist in relations to each other. (e.g. Marcus 1995; Hine 2007; Beaulieu & Scharnhorst & Wouters 2007.)

Furthermore, these relations between different sites are multiple as well, and there are not any a priori defined relations between different sites, such as, for example, policy/protocol and clinical work. Let me elaborate on that with the policy work vs. clinical work example. First of all, the site(s) of doing policy and protocol that is in most cases informed by statistical and quantitative research results. In other words, it is informed by a measurable change in a large enough number people, and intended to alter individual’s situations (cf. Mol 2002, 127-142). However, the relation between individuals and populations or clinical practice and policy practice is not that of a straightforward inclusion or causality, and this seems obvious in the light of my own research, as well as in prior studies (e.g. Berg 1998; Mol 2002; 2008).

In fact, although policy and protocol documents obviously inform clinical practices around maternity health care in contemporary Finland, the work object of the two sites is not the same. The protocol and policy documents are concerned with *public health*, and they suggest that if the right information is given to right people they will act on it. Nevertheless, the work object is not the individual who is supposed to act, but the population whose wellbeing is statistically measurable. (see also Berg 1998; Mol 2002, 119-133.) In Finland the concern over young children’s and families’ psychosocial wellbeing in the public and policy discussions before the construction and implementation of the new MCH protocol was arrived at by counting the admittances by the administrative agencies by hospitals and other special services. These calculations were furthermore fed into governmental research institutes for the study of epistemology and so on. Along with the prevailing agreement that health care should treat ‘patients’ or ‘clients’ as wholes that includes a family (cf. Mol 2002, 119-120) all this has resulted in recommendations for care work that requires the participation of a broad array of medical, social and psychological workers and technologies, and families themselves.

Surely, when assessing and working with individuals and individual families, heath care professionals take into account their knowledge of the frequency of particular problems in the population, but this does not mean that statistics and (new) protocol informed by such numbers will straightforwardly redirect the efforts of each professional from tinkering with individual cases to working with a new 'whole' of different kind (cf. Berg 1998; Mol 2002; 2008). Different professionals in the care teams have different work objects and knowledges, and thus they have very different views of problems, client selection and reasons and means for intervention. Physiological, social and psychological aspects of pregnancy may all be dealt with, and a workable solution and practice are reached for each given case. Yet, it seems that, in practice, there are frictions, tensions and power relations at play in the processes of realizing such practices at the clinics.
In the following, I will attend to the practicing of the new working methods (home visits during pregnancy, multi-professional team meetings and interviewing with 'welfare assessment' forms) as I have observed them and the 'goods' embedded in them. Simultaneously, I will further address the issue of what is it that protocol *does* in maternity health care practices. In other words, how does pregnancy and pregnant persons enacted (anew) travel around the institution: From policy and protocol to other practices and back again?

Pregnancy as the socio-materialities of the home and the 'goods' of what is not possible

In a quite recent research project about the impact of maternity and child health care methods (Pelkonen, Löthman-Kilpeläinen 2000) there was a positive correlation found between home visits and psycho-social well-being. Also, according to the new Finnish government recommendations nurses should make a home visit at around 32-34 weeks of gestation, and pregnant women's partners should also attend these visits too (*Child health care clinics supporting families with children* 2004). Indeed, home visits were highly valued by both public health nurses and the pregnant women I interviewed and talked to in the waiting rooms and halls of the clinics. The pregnant women usually referred to the postnatal visit and they appreciate the fact that they did not need to visit the clinic so soon

after birth and for the advice they got from the nurses regarding breast feeding and child care.

The nurses I interviewed, in contrast, described the home visits as occasions for observing family interactions, and the material conditions of the home. They reported that would pay attention to the *cosiness* of family life: the way family members talk to each other, the way they arrange their home activities including the place for the baby(-to-be). They stated that they would attend to the smells, the dirt, the equipments for the baby, the safety of the accommodation for children and so on. In one word – they noted the *materialities* of the domestic environment. They also observed the sociability of the practices and they insisted on materialities.

Home visits are thus a particular site of enacting pregnancy. For the health visitors, they are sites for observing family life. Pregnancy is enacted through the practicalities of a home that are simultaneously social and material. Pregnant actors are the observed, possibly in need of protection from future 'problems' or immediate intervention of some kind. 'Need' is the central term here. The nurses do not make home visits to find out what the future parents want when it comes to family communication or home environment, but to enquiry into how to adjust different elements of family life as good as possible. This does not mean that the family members are not asked about their 'needs'. In fact, it is an ongoing practice that permeates different sites of maternity health care work: from consultation rooms to home visits. Furthermore, 'needs' are not only asked about but conversed about. What might be done differently to improve things? Could some field of welfare services be of help and how? Help may come in the form of conversation, but also in a physical and material form. It may be a visit to a family council class, rearranging the furniture in a home or weekly domiciliary care worn (nowadays provided by so called family care worker).

However, the pregnancy as observed materialities and material practices that so nicely coincides in a research setting and guide-line documents with other enactments of pregnancy in different sites at the clinics in different work practices (such as interviewing

and hands-on investigation), turns out to clash at the clinics where I did my fieldwork at. This is so not because materialities of the home would somehow fail to contribute to the psycho-social welfare of a family or assessing it, but that the nurses I followed around with had to attend to appointment work at the clinics first. In fact, at the time of my fieldwork, there was not enough time or staff to make prenatal visits at all. As a result it can be said that a hierarchy of a kind is established, and pregnancy as observed materialities is so far an impossible condition, simply because the home visits were not done at this point due to lack of time and other resources, and because they were not prioritized over appointment work at the clinics.

Managing cooperation, managing pregnancy 'goods'

According to the new guide-lines for multi-professional team work ' [f]amilies in need of support have diverse problems, and cooperation of professionals from health care, mental health and social services is needed to support these families [- -] In a MCH clinic the public health nurse and the doctor are not solely responsible for supporting clients, but responsibility is shared with a multi-professional team' (Kangaspunta & Värri 2007, 3-4; see also Kangaspunta et al. 2005; *Aims and scope of the Family-oriented MCH clinic 2007*; Hakulinen-Viitanen & Pelkonen & Haapakorva 2005). The guide-lines also specify all the requisite members of the team (a social worker, 2 family care workers, an obstetrician/pediatricion, psychologist, 2 public health care nurses, in every other team meeting a social worker from a family counseling centre and a day care representative when needed). Additionally, these guide-lines also include rules which are designated to provide the foundation for the organization of team work: The team must choose a new leader every once in a while amongst the team, and this leader works as a secretary for the team meetings, and each member should bring in cases to discuss in *decision-making meetings* and, when possible, they should invite families for a *consultation meeting*. In practice, at the clinics where I did my fieldwork, the nurses were the permanent team leaders and they invited all the families to come to the meetings and proposed the most cases to be considered at the meetings. The general view, as well as the operating principle, was that the team works as a consultation aid for the nurses, especially

according to the doctors' opinion (interviews). So the client flow is not redirected in a large degree here; they still travel into the other welfare services in accordance with the nurses' judgment.

Yet, the significance of the team metaphor and cooperation is greatly emphasized in order to make things work. To work with 'a family as a whole' involves diverse skills, perspectives and background which attend to different issues: Social workers address financial, child welfare, employment and social support issues; psychologists address mental health issues; the doctors address maternal health, obstetrics, postnatal treatment and pediatrics; family care workers address home aid and child care; and public health nurses act as mediators in the sense that, in practice, they screen the pregnant women and their families on the basis of their knowledge and training in both the physiological and psychosocial aspects of pregnancy. However, this cooperation is not some naturally occurring phenomenon. First of all, it becomes an end in itself, designated satisfy institutional requirements: co-operative meetings have to be held, and reported on. Secondly, it is the means to achieve certain ends, and these ends are linked with the work objects of practitioners (and of practice) that do vary and which do not always coincide. All the participants, including the pregnant families, talked at the clinics about the importance of multi-professional cooperation and about the advantages of team work when working with families as wholes, but the cooperation is, in fact, an achievement of coordination. (cf. Casper 1998.)

According to the lines of professional responsibility the agenda, practice and object/subject of practitioners work seem to differ. Social workers work with 'responsible parents', 'children in need of protection' and 'families in need of financial aid'. The psychologist's concern is with family relations and family members' emotional life. Doctors attend to physicalities of the pregnancy, the fetus and small children. Family care workers do hands-on work with the materialities of home life and child care, and the nurses are intermediary actors that seem to have authority for all the 'clients' that visit the clinics.

Here is an ethnographic snapshot story from my material to illustrate how cooperative agreement is achieved via *coordination* of different work objects and agenda. Furthermore, it shows how, in practice, 'information' or 'facts' get to be chosen to be presented to the families:

> *It is a consultation team meeting. A 15 year old teenage girl who is pregnant, 34 weeks gestation, and her mother are coming into the meeting. The meeting starts with the public health nurse describing the situation to the other team members. She explains the situation, and the others ask questions. Before the pregnant girl and the mother come in, the team agrees on how to proceed with the discussion with them, and on an initial plan of referring the pregnant girl to different welfare services. The story of the girl goes as follows: At the age of 14 she met an 18 year old man online. They met up and had sex few times, and now the man refuses any contact even after having been informed about the pregnancy. The girl became pregnant and had been hiding the pregnancy until just few weeks ago. Finally somebody at school had informed the school nurse who after meeting with the pregnant girl took a pregnancy test. After a positive result the mother of the girl was informed and the maternity health care clinic contacted. The girl had met with the nurse once the next week after the visit to the school nurse, and soon after that a consultation team meeting was suggested to the girl and her mother. The public nurse describes the girl as very confused and silent, and scared about giving birth and not knowing how to take care of the baby. The nurse had brought out the question about making a criminal charge against the father of the baby-to-be, but the family of the pregnant girl does not want to do that. The girl has said fairly little about the father of the baby-to-be and 'seems to be hoping for a some kind of relationship with him'. At this point the nurse expresses her regrets that the social worker from child welfare services could not attend the meeting for she would have had knowledge about the procedures involved in making criminal charges without the family's consent. The psychologist expresses at this point concerns over the emotional relations of the child(-to-be) and her farther. Finally the team decides to deal with child welfare issues of any kind later on, maybe even after birth, and only concerning the social rights of the baby. The protocol for the meeting is agreed on: Go with the practical worries the pregnant girl and her mother have right now, such as planning a caesarian operation and arranging for help from family care workers. (Videotape 5.6.2008)*[15]

[15] The particular videotape which provides the bases for this account is one of the few I have from a team meeting with a client consultation. Clients are asked to come along when the nurse thinks that consulting with a team of experts could be beneficial when considering further helpful health care services for the family in question. Most of the meetings are decision making meetings among the team members only. I have made *ethnographic descriptions* of all the videotapes to make the material more manageable for analysis. Partial CA transcriptions of the tapes do exist, and I do keep on going back to them and the videotapes them selves.

What I want to draw your attention to is first of all the tension between the psychologist and the nurse and social work as it seems to be understood in this snapshot. When negotiating what to do in the case of a statutory rape the psychologist, who most likely does not dismiss juridical criteria of statutory rape[16], enacts a pregnancy (matter) and value that differs from the one that is in the focus of the nurse and the social worker: that of the 'goods' of emotional family relations and transition to parenthood. This enactment of psychological actors is in tension with that of social work's object of child welfare (referring to the pregnant girl who is under the age of 16). Finally, in this specific instance, the differing work objects and matters of concern are managed by *distribution*. By distribution in this particular case I am referring to movements done over time and over work objects. Child welfare action is moved in time to the postnatal future, and its object is transformed into the newborn. The here and now object to be addressed that is finally arrived at together is that of social and psychological worries over practicalities of teenage pregnancy.

The matter of which issues for conversation, information and advice given are chosen (and how they are articulated) is not neutral. *Should* the issues be those of juridical and child welfare origin, or perhaps those addressing emotional transition to fatherhood? Whose good are or should be sought after? Doing 'good' for a collective of a 'family' is not necessarily the same thing as improving the situation of a family member, such as the pregnant woman. Additionally, since issues brought up often lead to actions, what might they cost? Overall, facts are closely linked to values that are simultaneously managed in the team.

Pregnancy as *practicalities of teenage pregnancy* here also alter the 'what to do' with physicalities of pregnancy: The decision to do a caesarian operation had been arrived at before the team meeting and after the young woman had only one visit to the clinic. In Finland, and in the clinics where I did my fieldwork, deciding for a caesarian section in because of fears about giving birth is regarded as a last resort. Usually healthy (physically and psychologically diagnosed) women expressing fears about the prospect of giving

[16] According to Finnish legal jurisdiction the age of consent is 16 years.

birth are referred to psychologists and/or to a special outpatient clinic (*pelkopolikliniikka*). Hence, there is another way of coordinating differently enacted pregnancy matters in this snapshot: that of *addition*. The particularities of a (psycho-)social context of this (teenage) pregnancy is taken in itself as signaling the need for treatment, even though this is not indicated by the overall health of the pregnant woman.

In all, negotiating or coordinating different work objects together is not just about managing tensions but also about, or intertwined to, sharing tasks, *in an ever-changing way*. Pregnancy is a process in which the here and now project may be to arrange a 'proper' home environment for a newborn to arrive with the help of family care workers. Little further along the matter of concern is the caesarian section with doctors, machines and medication. Tasks, then, are not just divided between the human professional members of the team but involve bodies, technology, clients, patients and families.

The more or less balanced judgment made does not proceed team practice, nor can argumentative ethics be disentangled from it. It is impossible to be sure what is good to do and what might be the consequences of each decision, but in a team one does not have to think it through alone. It seems that in the teams technicalities are kept and even forced open when different professionals call each other to argue their suggestions for action. Furthermore, regular meetings ascertain that this work of tinkering with technicalities is a process: if something went wrong earlier, what was it that went wrong with the activities? How can *we* assess better?

Materializing screening tools or probing questions? – interviewing with the new forms

Using forms to collect information from and about pregnant women is not new to Finnish maternity health care. The collection of information has been coordinated by a computerized casebook system since the early 1990s. Public health nurses are required to record the results of routine tests taken at every appointment (urine test for sugar levels, blood pressure, fetal heart beat and weight) and whatever information comes up about physical and mental health, family and other social relationships and about the financial

situation of the women and their partners. They also use the casebook system to retrieve information entered into the system by physicians, hospital staff and ultrasound technicians or midwives. While the system is often used only briefly during the appointments and information entered into it mainly after the appointments, during the 1st appointment information is filled in simultaneously. This is because the 1st formal assessment needs to be completed for the individual pregnant woman's case to become actionable. According to the established protocol the nurses are held responsible for completing the scripted interview during the 1st appointment. Overall, the forms and the casebook system are used as a method to ensure the complete and adequately detailed gathering of information.

In addition to regular updating of the routine tests and open commentary entered into the casebook system and the maternity card (that pregnant women are expected to carry with when visiting any health care facility while pregnant), before the welfare assessment with the new forms there is only one set of forms that are used in the appointments. Those are the forms for the Social Insurance Institution of Finland. 18-22 weeks gestation pregnant women and/or their partners need to fill these out and send them in for maternity, paternity and parental leave and benefits. They do not need not to be completed at the appointment, but, in practice they usually are. Health nurses reserve one appointment for this, and it is recommended in formal guide-lines that health nurses should advise parents about the quite complicated application procedures and the options of different kinds of leave arrangements (*Handbook for maternity health care 2007*). Additionally, the nurse provides the parents(to-be) with a certificate of pregnancy that is needed for the application process.[17]

The new welfare assessment forms were developed specifically for the new maternity and child health care clinic work. The structure of the form is in line with the 'psychosocial welfare' division, and the form is presented in appendix 1. This quite numerical form was developed together with staff from the Department of Psychology at the University of

[17] At the end of the 1940s maternity benefit payments were made conditional, as women were required to visit a midwife or a doctor before the 16th week of their pregnancy in order to be eligible for these benefits.

Tampere and practicing maternity and child health care psychologists who at the time also worked for the municipal administration of maternity and child health care. Apart from 3 open-ended questions at the very end of the forms, couples are asked to fill in their answers on different scales according to how well the given statements corresponds with their own situation. Hence the forms in themselves are very fixed and compartmentalizing.

The forms consist of 9 different more or less standardized multi-item scales. The scales are supposed 'screen' for and report on available 'social support' (revised Perceived social support scale), 'mood' (Edinburgs Depression Scale), 'use of intoxicants' (shortened version of the Alcohol Use Disorder Identification, AUDIT, scale), 'resolving conflict' (Strauss Conflict Tactic Scale), 'stress in the family with small children' (10-item scale developed by the project team to screen for stress related to entering into parenthood and managing life in general), financial situation (2-item scale developed by the project team), 'fears and worries of the expectant' (basically screening for fears about childbirth, 7-item scale that is widely used in Finland, Salmela-Aro & Nurmi) and 'mental images of the baby(-to-be) (12-item scale developed by the project team to assess images of 'early temperament' and 'early interaction'). (Kangaspunta & Värri 2007; Kangaspunta et al. 2005.)

As a practice (of representation) in itself the form, then, assumes a pregnancy around which specific qualities can be attributed and that can be quantified in these specific and detailed ways. In doing so, it determined 'good life' in a way that evens out and objectifies the differences that 'quality of life' might mean for different people (cf. Mol 2002, 174; 2008). It also assumes a person who is capable of doing this work of attributing and quantifying to one self when it comes to emotional, psychological, social and economical issues. Consequently, they also assume a person with a fixed or frozen sense of self, her pregnancy (matters), and her social relations. It could also be added that the forms assume that behavior derives straightforwardly from feelings, thoughts and attitudes since embedded in the forms are the demands of the protocol and policy of Family-oriented MCH care that aims at screening of psychosocial problems and at thus

preventing problematic behavior (Kangaspunta & Värri 2007; Kangaspunta et al. 2005). The forms, then, work as a kind of *materialization* of the demands of the protocol.

Even if the form as a technical innovation turns quality into quantity in this way, it can't be said that it is not in any way an active participant of good care. Technology cares too by transforming practice and moral orders. It is practice that reveals how nurses and future parents use the forms, and it is practice that bears open what is done that might not be done without the forms. Thus, the form as part of care taking does not really exist *in itself*, and this is something I will try to address in the following paragraphs.

First of all, there is guide-line protocol that is disseminated in training events and in written form and that focuses on the use of the form. Secondly, protocol with its material form-tools, does not merely replace and standardize procedures and guide personnel and pregnant women and their families, but *transforms* the practice and is *transformed* itself in the processes of construction and implementation of the protocol (Berg 1998, 229-232). These issues I will try to address in the following paragraphs.

According to the guide-line protocol the nurses are supposed to make numerical assessments based on the forms, and the written protocol includes instructions on how to do this and with critical scores being assembled for each scale. The guide-line protocol also states the further action that should be considered in a case where a critical score is exceeded. However, the texts are quite abstract and brief about this. Further action is usually described in terms of consulting with a doctor, referring to a psychologist and bringing the issue up at the multi-professional team meeting. (Kangaspunta & Värri 2007; Kangaspunta et al. 2005; observations at nurses' trainings spring 2007)

Furthermore, the information provided by the future parents on the forms is not typed in the patient casebook system at all. In fact, the assessments are meant to be entered in to the case files only in case some of the scores exceed the critical score set for a given scale. Moreover, the casebook system does not include an online form identical to the paper ones. Hence, although the form itself contains a sturucturing as a series of 'if one

gets a score like this, then further action must be taken' statements the knowledge obtained does not travel into the casebook system as this kind of formalist, well-defined and clear-cut input. The nurses have told me and it has been said in the training events I have observed that only statements such as 'assessment has been done and there seems to be no need for concern' or 'the pregnant woman seems not to relate to her unborn baby in any ways. A visit to a psychologist was brought up, and she promised to think about it' are entered. Also, the material forms themselves are not to be filed away.

In addition to instructions on how to enter information about the assessment into the casebook system, and, thus, into case histories, there is some written guide-line protocol on how and when to use the forms in the interviews. Overall, the instructions are quite short and vague. Nurses are instructed to give the (pregnancy) forms to couples around 24-26 weeks of gestation and to make an 1-1,5 hour assessment interview appointment with the couples[18] around 28-30 weeks of gestation. The are advised to "use their interviewing skills obtained from training on 'early interaction'"[19], that 'the forms should be used merely as tools for bringing up difficult issues in discussions between couples and between the couples and nurses' and that 'the interviews should be done with every couple to avoid labeling families, and to find out about problems that may not surface otherwise' (Kangaspunta & Värri 2007; Kangaspunta et al. 2005; material distributed at nurses' trainings spring 2007).

So, although the guide-line protocol statements do not seem to be designated to standardize methods of interviewing with the forms or make it clear-cut, they do articulate activities over different sites and times: the nurses know when to hand out forms, when to do the interviews, who is included, what might be expected and how the interviewing activities fit the overall picture of maternity health care work and actors. In other words, the form does to a certain extent prestructure the nurses and other maternity health care personnel's work environment, and guides the personnel through sequenced

[18] Both the pregnant woman and her partner are expected to attend the appointment, unless of course the woman is a lone expectant.
[19] All the nurses at the clinics where I did my fieldwork at had had this training that concerns interviewing skills with expectant families and families with small children, and that aims at bringing up problematic issues (see also Davis et al. 2001).

paths of action, geared toward certain features of the pregnant women, their families and their life situations at hand (cf. Berg 1998, 232). Also, the guide-lines redirect some client flow in that clients are channeled through these interview sites into team meetings and other health care services. It can be said that psychosocial pregnancy with its origin in the new form is multi-sited, and ultimately behind those sites is a common object. For instance, the results of the summed up scores and the 'results' of the interview are presumed to overlap. They are to be *added* to each other when screening for problems.

When exploring another site concerning interviews, that is the interviewing that takes place at the clinics every day work, this overlapping appears quite complex. Furthermore, when the form actually intersects with the work practice involved, it is only possible to observe, how what it is that the forms are meant to report about psychosocial situation of the families is really *translating* those situations and *negotiating detail* into a mode (of knowledge) that can then be moved or not moved to other places. Simultaneously, roles and tasks of people involved are affected and pregnancy matters are redefined.

In contrast with other interviewing sites, such as the 1st appointment interview, at the assessment appointment the nurse does not sit in front of a computer. Instead, chairs are pulled around an empty table. In affect, the space is organized not as a formal interviewing space, but it is set-up as if for a casual conversation. The appointments usually start off with general discussion about what has happened since the last appointment and about how the pregnant woman and her partner are doing. By this time, nurses most often know the pregnant women and their partners quite well, because these interviews take place when the women are 28-30 weeks pregnant, and they have met with the same nurse approximately 10 times and in most cases they have consulted with them over the phone as well. After this warm-up discussion the nurses describe the forms using terms such as 'tools for discussion for future parents', 'not compulsory', and they emphasize the fact that the information given are not to be entered into any official records. In a way, they tend to direct the interview toward a discussion that is led by the nurses themselves. A lot of effort is put into the sociability of the event.

All the subject areas on the form are covered during the appointment and sometimes in the same order as in the form, but not in a structured way. Nurses diverge from the structured form in many ways. For example, nurses encouraged the couples to talk in their own words and not use the forms' statements. In fact, in the appointments I have observed the nurses do not often look at the completed forms of the parents. They have an empty form in front of them only to keep track of the overall structure.

The fixity of the form is additionally transformed by the nurses' summarizing questions into one question, by approaching a whole subject area in the form from a different angle, by returning to earlier discussions at other appointments, by giving words of comfort and suggestion, and sharing experiences. They also give back information about the forms in general, about the 'meanings' of particular questions and about questions quite unrelated to the forms, such as questions about physiology, medical procedures and so on. In fact, it seems that it is more often the pregnant women or her partner than the nurse who relies on the fixed categories of the form. The nurse may start off with an open question, such as: "How do you deal with conflicts in your house", and the woman picks up the form and starts reading the statements and giving numbers.

It is only when the nurses seem to detect a problematic answer (in terms of the guide-line protocol for using the forms distributed to the clinics and on the basis of their 'sensitive probing' that nurses usually assign to 'work experience' and 'people skills') that they lean over and look at the answers filled in by the pregnant woman or her partner. In these instances, the conversation over a specific subject area lasts longer and becomes more detailed, and this is initiated by the nurse. On other occasions, when nurses 'see nothing worrying' the subject can be passed over quickly. If one partner in the couple indicates particular worries at any point during the session, the nurse does try to address them as thoroughly as possible, given that there is a time limit for this appointment too.

I will illustrate all this through another snapshot representation deriving from ethnographic research. This revolves around alcohol consumption (use of intoxicants part in the form in appendix 1). In the following description of the activities in a videotaped

episode, the nurse is interviewing a pregnant woman and her partner about alcohol consumption at a welfare assessment appointment. Here, we can see how the form is used to work to evoke or negotiate detail:

> *The partner of the pregnant woman has filled in that he only drinks once a month or less. However, he has filled in that he consumes 10 or more unit per time, has hangover drinks, and feels guilty about drinking. The nurse indicates that she is worried and wants to hear more, especially because the partner had the similar scores in the 1st appointment interview. It turns out, that when the partner does go out drinking the drinking usually lasts for couple of days. He had interpreted hangover drinks to include drinking sprees of more than one day. Furthermore, he elaborates that feeling guilty does not mean that he thinks that there is something wrong with his behavior. Rather, he associates the feeling with the features of a hangover. He does not think anybody ever criticizes him, and has filled it out also in the form. At this point, his pregnant wife joins in to defend him. She says that she does not think this kind of once-in-a-while drinking is a problem, and that she always knows where her husband is while he is on a drinking spree. The nurse seems not to be convinced and advices on the dangers of heavy drinking. She also works on the couple's feelings toward drinking by suggesting in various ways, why they should be worried and critical about drinking in this particular way, and how pregnancy is the time to make these changes before the birth of the child*. (Videotape 3.4.2007)

Here we see how the 'order' that can be seen embedded in the form, and that can be seen as imposed on the person filling it out is in practice *transformed*. In the partner's interpretation 'feelings of guilt' are not linked to his particular drinking habits, and this is in contrast to the presumptions embedded in the AUDIT-scale. Furthermore, his pregnant wife agrees with his interpretation. To arrive at this kind of information, and for it to count as information, there needed to be room for elaborations and personal detail within the work of assessment. In the interviewing site, then, the characteristics of alcohol consumption in the partner's account certainly add on the one that the form is supposed to report on and on the one the practice-oriented, yet abstract and not detailed, written guide-line material outlines. However, here alcohol consumption and consumers of alcohol enacted do not overlap. Instead, they clash. The tension between the two interpretations of problematic drinking is not smoothened away since the nurse expresses concern and gives information and advice against that kind of heavy drinking.

Moreover, what seems to reinforce the nurse's concern is the case history, the client itinerary, that works as a tool for distributing over different sites at the clinic and over time. In the case of this particular family, the nurse has paid attention to the partner's drinking habits already at the 1st appointment interview and the AUDIT test scores have been entered into the patient case book system where they can be retrieved and brought into to discussion at the assessment interview. The nurse is especially worried, because the drinking habits have not changed 'for the better'.

Yet, the nurse does not dismiss the partner as a 'bad investment'. Instead, she seeks for moderate drinking, *moderation*. This is not only done by presenting confronting arguments but by telling stories that enrich each other even if a common conclusion is never reached. Translating and adding detail as activities are moral activities. They help to answer the question of how to better something that went wrong before or elsewhere, and how to transport success to other situations and sites. Good conversation is good care; take the issue up again and again, try again, try something new.

Concluding remarks: ethnography and (Finnish) maternity health care practices

By observing and writing about the 'goodness' of care I do not mean to imply that Finnish maternity health care practices are magnificent. In fact, there is a lot left to improve, and I agree with a lot of writers on ethics of care (e.g. Held 2006) and on (maternity) health care as a site for population politics/policy (e.g. Nätkin 1997) and/or an institution of public management (of women) (e.g. Wrede 2001) that as a (work) practice or cluster of practices care is most often embedded in unsatisfactory contexts of domination or, to use Smithian terms, 'ruling relations'. Neither do I intend to argue that 'patient choice' that come in the form of the way of the market and in the form of the civil society does not or should not organize 'good' care. Rather, it is a question of where and when setting up situations of 'choice' appear appropriate, and when and where other line of activities might be better. Hence, it is a question of improving and observing the goodnesses of care ' in its own terms', in the practices. (Mol 2008, 73, 83-94.)

Good care is not some form of tender loving and empathy, although they may be a welcomed addition to care. Annemarie Mol (2008) writes that at the end of the day good care is attentive and bad care is neglect. It is *work* or form of labor (Held 2006, 36-42) that includes bodies and physical hands-on work and fine-tuned technologies and materialities. Good care is also shared work and a process of attuning to specificities of the conditions of those cared for in ever changing ways. (e.g. Mol 2008, 73-94.)

In this paper, I have tried to address how these 'standards' for care are realized in the changing Finnish maternity health care practices via ethnographic fieldwork. More specifically, I have attended to care practice via multi-sited and, thus, 'middle-range' (e.g. Hine 2007) in its construction of the ethnographic object. The places and spaces of my ethnographic approach are not conceptualized a priori as micro and macro levels of institutional organization or analysis, as is the case in many other contemporary STS ethnographic case studies (e.g. Beaulieu & Scharnhorst & Wouters 2007). They are understood as interrelated sites (Mol 2002; 2008) or situations (Beaulieu & Scharnhorst & Wouters 2007) of doing (good) care of pregnancy in maternity health care.

Yet, I do not want to loose the sight of institutional management of pregnant women in their bodies. I have tried to achieve this by bringing in elements from Dorothy E. Smith's (1987; 2005) institutional ethnography that aims to map the ruling relations that coordinate care work, including the work of the pregnant actors. Particular writers in STS, then, provide my ethnography tools to address the fact that in the lived reality things do not always go how they 'should have', according to some systematic logics. Here, at a less discursive or systematic range, at the level of practices that does not necessarily follow discursive logic, ethnographic fieldwork, that involves a long period of time following people around and talking to them in the field, becomes vital. I don't really see how else one could address how institutional activities and the morals invested in them become more complicated with material practices.

What, then, can I say about the 'goods' and 'bads' of the changing Finnish maternity health care in the 3 clinics where I did my fieldwork? It can be said that pregnancy as a

matter of concern is further multiplied and care work further coordinated in the realization of the Family-oriented MCH clinic intervention. Some old hierarchies seem to be reinforced while others unravel and new ones emerge in a continuously changing manner.

Let me elaborate on that. Pregnancy is now simultaneously a public health matter that is linked to observed materialities of the home, and different agendas and work objects employed by different social, psychological and health care professionals. It is attributed certain new 'psychosocial' characteristics and quantified in standardized ways in the new forms, and the unraveled into more undetermined terms in a good sociable conversation at a consultation room when interviewing with the new form, a multi-professional team meeting or at a family home. Good conversation may in itself be good care/cure when it attends to the needs of specific individuals or individual families by for example asking about needs, translating answers and negotiating detail. Needs may also be addressed in a physical and material form. It may be hands-on breast feeding guidance of a family care worker, rearranging the house furniture or caesarian section for psycho-social reasons. Although, everything is obviously not possible, in care, social transfers the physical, technical and material conditions is pregnancy, not just vice versa, when the care team of people, machines and materials work to adjust prenatal family and individual life as good as possible.

This is not always easy, and set goals are not always met. However, this does not make care bad even though there might be a lot left to hope for. In general, the nature of dealing with physicalities, social and psychological issues in (maternity health) care seems to be managing unpredictability (cf. Mol 2002; 2008) – of diagnoses/screening results and the results of actions/treatment taken. This management involves work coordination and sharing tasks between the care team participants. Attuning to pregnancy as a process is about movements over time and work objects: for example from material practicalities of a home right now to child welfare issues after birth. Everything can not be achieved but families are not left alone to think through things, and different professionals are brought closer to the everyday life of the families and the clinical

practice with the introduction of multi-professional team work. It also seems that this way technicalities of assessing and treating are kept open to attend to how things have proceeded and to negotiate professional activities to be taken in every individual case.

Old hierarchies are in some cases reinforced, and sometimes this leads to bad care. First of all, when clinical work overrides home visits because of the lack of time and money the materialities, physicalities and sociability of the home and needs intertwined to them are not attended to. Secondly, because at the time of my fieldwork, the client flow was not redirected basically at all away from the nurses and appointments work, and screening for physical abnormalities was prioritized over team work as well as home visits, diagnostic, some treatment and further action decisions are left for doctors, psychologists and social workers. Thus, the standard of sharing and managing tasks together is not really met. Thirdly, sometimes when the new welfare assessment interviews are not done or discussed properly conditions, hopes and worries of pregnant women and their families are not addressed at all or decision power is somewhat shifted to statistically measurable predetermined elements, of psycho-social wellbeing. How, then, can care be attuned the various relevant elements in good care to each other?

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Appendix 1: The welfare assessment form

When you are in need of support…

Below you will find descriptions of resources for social support
Assess in a scale of 1-5 how is it possible for you to get help and support
Choose one option for each statement

	disagree	Rather disagree	N/A	Rather agree	Agree
I have an important person in my life who supports me, when I need help	1	2	3	4	5
I have an important person in my life with whom I can share joys and sorro	1	2	3	4	5
My family always supports me, when I need help	1	2	3	4	5
I have an important person in my life, who consoles me	1	2	3	4	5
My friends really support me, when I need help	1	2	3	4	5
I am able to talk about my problems with my family	1	2	3	4	5
When I need to make important decisions I get help from my family	1	2	3	4	5
I am able to talk about my problems with my friends	1	2	3	4	5
Close people in my life help me with practical things	1	2	3	4	5
Close people in my life won't let me down if I have financial trouble	1	2	3	4	5

Mood

Answer the following questions by circleing the option that corresponds to your feelings during the last 2 weeks.

I have been able to laugh and see the bright side of things

0 Just as much as before
1 Not quite as much as before
2 Clearly less that before
3 Not at all

I have been looking forward to the future happenings

0 Just as much as before
1 Not quite as much as before
2 Clearly less that before
3 Not at all

I have blamed myself for no reason when things have gone wrong

0 Just as much as before
1 Not quite as much as before
2 Clearly less that before
3 Not at all

I have been anxious and worried for no apparent reason

0 Just as much as before
1 Not quite as much as before
2 Clearly less that before
3 Not at all

I have been scared and frantic for no apparent reason

0 Just as much as before
1 Not quite as much as before
2 Clearly less that before
3 Not at all

Things seem to be falling on me

0 Just as much as before
1 Not quite as much as before
2 Clearly less that before
3 Not at all

I have been so unhappy that I have hade trouble sleeping

0 Just as much as before
1 Not quite as much as before
2 Clearly less that before
3 Not at all

I have felt sad and misserable

0 Just as much as before
1 Not quite as much as before
2 Clearly less that before
3 Not at all

I have been so unhappy that I have been crying

0 Just as much as before
1 Not quite as much as before
2 Clearly less that before
3 Not at all

I have thought about hurting myself

0 Just as much as before
1 Not quite as much as before
2 Clearly less that before
3 Not at all

Use of intoxicants

How often do you drink beer, wine or other alcoholic beverages?

Never
Once a month or less
2-4 times a month
2-3 times a week
4 times a week or more

How many portions of alcohol do you consume during the days, when you do use alcohol?

1-2 portions
3-4 portions
5-6 portions
7-9 portions
10 or more

Have you ever been criticized for your drinking?

yes
no

Have you ever feld guilt because of your drinking?

yes
no

Have you ever taken a hangover drink?

yes
no

Resolving conflicts

People have different ways of acting in conflict situations. What do you do when you have arguments or disagreements with your partner? Try to remember situations during the last year, and assess, how well each statement corresponds with your way of acting in a conflict situation.

	Not at all	Hardly ever	only on occasion	Rather well	Completely
I discussed about things rather calmly	1	2	3	4	5
I tried to explain my view on things	1	2	3	4	5
I debated fiercely, but did not yell	1	2	3	4	5
I yelled and/or called my partner names	1	2	3	4	5
I moped and/or refused to talk about things	1	2	3	4	5
I threatened to hit my partner or to throw things at my partner	1	2	3	4	5
I threw a thing at my partner	1	2	3	4	5
I grabbed my partner or pushed my partner	1	2	3	4	5
The fight ended up in a battery	1	2	3	4	5
I left to avoid talking about things	1	2	3	4	5
I went out to get some fresh air	1	2	3	4	5
We made up and were relieved	1	2	3	4	5

	Yes	No
I am worried about the psychological violence in our relationship		
I am worried about the physical violence in our relationship		
Our child/children have heard our domestic violence		
Our child/children have seen our domestic violence		

Stress in the family with small children

There is also stress and worries during pregnancy. Next there is some questions about your feelings and thoughts during the last two weeks. Assess how well each statement corresponds with your feelings

	Not at all	Some	I can't say	Very	Very well
I have felt myself 'stresses'	1	2	3	4	5
I trust that everything will be just fine in my life	1	2	3	4	5
Hardships have grown so big that I can not control them	1	2	3	4	5
I fell that my child will make me fell good	1	2	3	4	5
I am afraid that I will be left alone with my child	1	2	3	4	5
I am worried about the development of my child	1	2	3	4	5
I have a feeling that I am not able to care for my family	1	2	3	4	5
I fell that I am in trouble with issues related to parenthood	1	2	3	4	5
I am afraid that a child would limit my life too much	1	2	3	4	5
My current life is unsatisfactory to me	1	2	3	4	5

Financial situation

Does your family have hard time paying regular bills (e.g. electricity, phone, water)

5 Etremely hard
4 Rather hard
3 Quite hard
2 Little
1 Not at all

How much money does your family have left right before the pay day

1 There is more than enough
2 There is some left
3 Just enough to cover the expences
4 There is not enough to cover the expences

Fears and worries of the expectant

Preganancy is a happy time of waiting, but there might be some fears and worries connected to it as well. Below you will find a list of some common fears that parents have. Assess how much do you have these fears.

	Not at all	A little	Some	Much	Very much
I am afraid that I might fall and hurt my child	1	2	3	4	5
I am afraid of the pain of child birth	1	2	3	4	5
I am afraid that my child is not normal	1	2	3	4	5
I am afraid of hospitals	1	2	3	4	5
I am afraid that my wishes won't be heard at child birth	1	2	3	4	5
I am afraid of giving birth	1	2	3	4	5
I am afraid of having negative feelings toward my child	1	2	3	4	5

Mental images of the baby(to-be)

Next questions are concerned with expectations that you might have as a parent about your child-to-be.
Assess how well statements correspond your own mental images

I think my baby-to-be will	Not at all	Some	I can't say	Much	Very much
sleep regularly	1	2	3	4	5
be difficult to breast feed	1	2	3	4	5
will have a regular feedinf schedule	1	2	3	4	5
be happy and satisfied	1	2	3	4	5
feels strange to me	1	2	3	4	5
be happy by her/himself	1	2	3	4	5
calms down easily in my arms	1	2	3	4	5
be hard to calm down	1	2	3	4	5
wakes up all the time during the night	1	2	3	4	5
be restless and impatient	1	2	3	4	5
be disarmingly cute	1	2	3	4	5
give me great pleasure	1	2	3	4	5

Me as a mother/father (open questions, RH)

What kind of good experiences you have had as a child that you would like to pass on to your child?
What kind of bad experiences you have had as a child that you would not like to pass on to your child?
How do you think/would like your and your partners parenthood to develop?