The culture developed by midwives working in a midwifery group practice.

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The Culture Developed by Midwives Working in a Midwifery Group Practice

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Summary

The history of midwifery has been a long struggle between a male dominated priesthood, then later a system of organised medicine (also controlled by men) and a women's community apprentice-led network of helping and healing. The advent of the National Health Service (NHS) in 1946 and subsequent reforms of the NHS confirmed medical power and hospital births were advocated as the safe option (Donnison, 1988; Tew,1990) In 1992, the consumers of the maternity services and the midwives providing the majority of the care formed an alliance and petitioned the government of the day for a review of the service. This led to the publication of the 'Changing Childbirth' report (DoH, 1993) where continuity, choice and control were the fundamental principles.

This ethnographic study follows the setting up of pilot teams as a result of 'Changing Childbirth' that then became fully established into the local maternity service. The focus is on one of the teams; their search for identity and the establishment of a Midwifery Group Practice. It explores the midwives struggles to develop as a team and the changing relationships with each other, their colleagues and management. This study also highlights the changing dynamics of the woman-midwife relationship for these midwives, their own personal development and the impact the new way of working had on family life. Using policy ethnography, this study sets out to observe how a national policy (DoH, 1993) was implemented by the midwives providing the local service. It documents the transformational journey undertaken as they moved from practising within the confines of the hospital to a community-based service underpinned by the trusting relationship with the women in their care.

Acknowledgements

I wish to acknowledge the invaluable help and support given to me by my supervisor, Dr Lesley Griffiths. I am so grateful for her hard work and dedication that helped to steer me through this process.

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Part One

Chapter 1

Introduction to the study

Introduction

> "Continuity of carer is seen as being one of the fundamental principles underpinning woman centred care" (DoH, 1993, p.14).

This policy statement ('Changing Childbirth') influenced the reorganisation of the local maternity services in one particular location in England where the author works. In order to achieve the aims of the policy, the local services developed Midwifery Group Practices (MGPs). These offered a significant departure from the existing way in which services were delivered where midwives[1] worked in hospitals or the community. Hospital midwives either rotated through all areas (such as the labour ward, antenatal ward, clinic and postnatal wards), or alternatively remained in an area of practice for many years becoming an expert in only one aspect of midwifery practice. Community midwives visited the women once antenatally and then postnatally when home from hospital. Community midwives also held antenatal clinics in General Practitioners' (GP) surgeries, sharing care with the GP. This clinic appointment would provide a point of contact for the midwife and the women.[2]

This study will offer a description of observations made over a number of years of the way the implementation of a policy change, the 'Changing Childbirth' report (DoH,

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1 The author acknowledges that in midwifery there are both female and male midwives. However, for convenience she will use the female gender when referring to midwives.

2 When referring to 'women', the author means the women as mothers-to-be or newly delivered mothers.

1993), allowed midwives working in a Midwifery Group Practice (MGP) to develop a unique culture that enhanced their job satisfaction and provided truly woman-centred care.

As part of her job, the author was involved in the early stages of planning for local midwifery teams, thus occupying a privileged location from which to observe the developments. However, this privileged location also offered a set of particular difficulties linked to researching one's own practice as a relatively powerful 'insider'. These issues are fully discussed in Chapter 4. This study has evolved out of her desire to properly document and analyse these changes, in order to understand the processes which take place as policy is implemented in the workplace.

The author selected ethnography, and some authors have referred to this approach as 'policy ethnography' because of its specific focus on the implementation of policy,[3] as the method to best describe the details of the culture change which occurred whilst the midwives adapted to working in a different manner and environment. Though the study focuses on the members within one of the MGPs in particular, it also comments on the local maternity services that provide the organisational context for the changes. The author is well aware of the difficulties of the lone qualitative researcher (see, for example, McBride and Schostak, 2005). These authors declare that the qualitative researcher using observational methods will inevitably bring their own personal views to the reflective process of analyzing the data. It is this form of reflection that allows the reader to judge the biases and position of the researcher, but at the same time grants the researcher the opportunity of exploring their own interpretation of the data. The author explains and comments on these aspects of the study in Chapter 4.

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3 As described by Medd (2003).

Midwifery work

Midwifery has had a long struggle to gain acknowledgment as a profession (Donnison, 1988) and, within the framework of the NHS, midwifery finds itself still struggling to remain professionally independent from nursing and medicine. Some of the difficulties inherent in the development of establishing distinct 'professional' work groups have been highlighted by Miller, who defines professional work as being:

> "organized around the provision of services to clients, and professional work is distinguished by the occupational group's claim to special knowledge and the public's acceptance of this fact" (1981, p.98).

Miller goes on to point out that:

> "an element of self-interest and social service will remain inextricably linked within the culture of professionalism" (1981, p.103).

Miller's work, as discussed in Chapter 2 of this study, does much to illustrate the culture and dilemmas faced by professionals, not only in establishing their claim to this status but also the dilemmas faced in maintaining this culture when confronted with changing public attitudes and access to knowledge. In the present-day climate, midwifery, like other professions, finds itself working in healthcare organisations where a range of occupational groups work together. Competition and conflict between groups form one facet of this situation, in particular between managers and practitioners. The difficulties experienced in imposing management frameworks on occupational groups with a commitment to a service ethic are well documented. Exworthy and Halford (1999) discuss the problems encountered when professionals who base their actions on giving a high value to elements such as trusting relationships with clients and peer review, are working with managers who "claim their privileges on the basis of institutional hierarchical authority" (p.26).

Exworthy and Halford (1999) also assert that managers work as agents of the corporate body and are accountable to superiors within the hierarchy, frequently needing to meet political targets or standards which have little meaning or value for occupational groups engaged in the face-to-face delivery of a service. This, then, presents the professional workforce with potential tensions and possible conflicts. Thus, midwifery can be described as a perfect example of an occupation caught up in this environment of conflicting cultures.

Within this framework, the local midwives voiced their dissatisfaction with the fragmented nature of the service and with the advent of 'Changing Childbirth' (DoH, 1993) felt motivated to embrace change in service provision. In doing this, the local midwives were faced with a fundamental change of working 'ways' or 'culture', and it was the opportunity to document this change that first motivated the author to undertake this study.

Definition of culture

The author has encountered problems attempting to define 'culture' because, as expressed by Mullins (1999), 'culture' is a notoriously difficult concept to attempt to define. Robbins (1996, p.29) states that "Most people are unaware of just how much culture will affect them". Conversely, Etzioni (1964, p.31) makes the declaration that "culture is like fish to water. It is there all the time but the fish are oblivious to it". Therefore, we can deduce that this is a concept that most are aware of but find difficult to define. Put simply by Mullins (1999, p.803), culture can be defined as "how things are done round here". This simple definition provides the essence of the concept that is applied to every aspect of life: work, social and spiritual. Every individual is influenced

by different cultures surrounding them, as they function in each aspect of their life. For the purposes of this study, the author will be focusing on work culture, because it is this aspect that first sparked her curiosity and generated this research.

The aims of the study

This study will focus on the social organisation of work within the context of healthcare. As a response to the national policy, a local plan was devised to change the delivery of maternity services and these changes are documented in this thesis. It is a detailed description of the transformational journey undertaken by a diverse group of local midwives who elected to work together. As the Abbey[4] midwives moved from a familiar culture they traversed into uncharted territory, but had to develop their own working culture. The author was prompted to observe what elements, if any, of the 'known' work culture would be transposed to the new working environment and what 'new' elements would develop. She also observed how the midwives themselves would change along this voyage into the unknown. As already stated, a qualitative research approach was deemed most appropriate and ethnography offered the opportunity to provide a careful, thorough description of the processes of change.

The structure of the thesis

A first step on the research journey requires the researcher to ensure that their work is adequately linked to relevant work which has preceded their study. There are two reasons for this. The first is to ensure that the development of knowledge is cumulative and that researchers are able to build on the previous work and existing knowledge of the research community, thus ensuring the best quality work. The second is that scarce

[4] The name 'Abbey midwives' has been arbitrarily selected by the author in order to preserve the anonymity of the midwives involved in this study.

resources, especially in healthcare (and the opportunity to carry out qualitative studies over a period of years can certainly be viewed as a scarce resource), should be utilised in the most beneficial way for patients and staff. Re-inventing the metaphorical wheel of re-discovering knowledge already available needs to be avoided and reviewing existing research literature offers the opportunity to ensure the best use of resources.

Chapter 2, therefore, reviews the literature. When this study commenced a number of years ago, there was very little work cited in the literature that was focused primarily on midwives' work, as most of the studies of the day were looking at clinical outcomes for mothers and babies. However, since then, a number of studies have been completed, such as Stevens (2003) and Walsh (2004), that consider the work done by midwives.

Chapter 3 provides background information that sets the scene for the study. Chapter 4 describes the method chosen and discusses the rationale for the selection, highlighting the problems and potential dilemmas encountered. Chapter 5 discusses culture, from the broad definition of terms to the explicit in midwifery.

Part Two consists of the findings of this study. Chapter 6 describes the midwives working in the team structure and follows their development across the early days of the team. Chapter 7 describes the Abbey midwives' developing autonomy. Chapter 8 focuses on the changing dynamics of the midwife-woman relationship experienced by the Abbey midwives and Chapter 9 describes how these midwives have developed over time on a personal level, drawing on their self-analysis. Chapter 10 is the concluding chapter, drawing themes together and looking back at the transformational journey undertaken by this small group of midwives.

Thus, the following chapters will demonstrate that observational methods for this study were selected as the most appropriate, offering the opportunity to document, describe and offer interpretations of this new policy initiative and its implementation in action.

Terminology and definitions used in this study

The author encountered a great deal of confusion in the terminology and definitions used in the literature. In order to clarify the terminology used in this work, a reference list is included here.

Birthing Unit: a small unit designated for use by low risk women giving birth within a hospital environment but without direct medical supervision. These units are staffed and run by midwives. They may be physically distant (stand alone, free standing) from or alongside the main Maternity Unit or, in some instances, within the main unit but designated for exclusive use by low risk women. In some localities, these units were originally called the 'General Practitioner's (GP) Units'. GPs on the Obstetric Register would undertake intrapartum care and therefore were available to the local midwives in case of need. This has now changed and there is no GP involvement.

Birth/Birthing Centre: as above. This was the term chosen by the Abbey midwives for their unit, described in Chapter 3.

Casehold: See below.

Caseload: the concept of caseload is defined by the management of the local Trust as:

> "the practitioner (midwife) holding the responsibility for ensuring that each woman that has a 'booking' with the local maternity service has her care planned and provided." ('Local Trust' Internal Document).

It is the organisation of the provision of a package of care that is the essence of this definition.

Community Midwives: midwives that work primarily in the community. They visit the women antenatally and postnatally. In some cases these midwives may work in partnership with a designated GP or GP's surgery and share the antenatal care so that the women alternate between the midwife and GP. Community midwives then visit newly delivered mothers and babies at home, until discharged to the care of the Health Visitor and GP.

GP Units: see Birth Centres, above.

Hospital Midwives: midwives who work primarily within NHS hospitals (main unit). These midwives care for low and high risk women. They work in antenatal clinics, antenatal wards, early pregnancy units (within the unit), day assessment units (within the unit), labour wards, postnatal wards and, in some units, a maternity bereavement suite (within the main unit).

Midwifery Group Practice: a group of midwives working in a team, providing all aspects of care throughout pregnancy and the puerperium. This definition suggests more autonomy and the provision of all care throughout the maternity episode. The group is responsible for a defined geographical patch and provides care for that designated pregnant population. Each individual midwife is responsible for a personal caseload. The group is almost independent, though still under the maternity services management.

This is the term chosen by the Abbey midwives, as described in Chapters 3 and 6 of this study.

Midwifery Led Unit: see Birth Centres, above.

Satellite Consultant Clinics: in some areas, Obstetric Consultants will hold antenatal clinics in small local hospitals geographically away from the main unit. It is a service that caters for the needs of a local population. The local Trust, however, has withdrawn this service in the area covered by the Abbey midwives.

Team Leader: a member of the group that takes on the 'leader' role. The local midwives selected the option of having the 'Team Leader' role as a rotational yearly post that allowed all members of the group the opportunity to experience this role.

Team Midwifery: as described in Chapter 2, team midwifery has a variety of meanings. The basic concept is a group of midwives working together. This may mean a team within the hospital organisation, the community or 'integrated teams' covering both hospital and community. In some cases, in the literature, they may describe the team in the same terms as an MGP. Therefore, this term is very confusing. Some teams may specialise in low risk pregnancies, others in high risk pregnancies, yet others will care for a group of women regardless of risk. The term 'team midwifery' has developed myriad definitions.

Team Caseload: this is the shared responsibility of all members of the team to ensure that a package of care is provided and delivered to each woman allocated to the team. This means that each woman will be cared for by any member of the team that is

available. An element of continuity of carer is achieved, because the individual woman will meet and get to know a small group of practitioners.

Personal Caseload: each midwife in the team/group practice has the personal responsibility of ensuring that each woman allocated to her receives a complete package of care throughout her pregnancy. In practical terms, this means that the midwives' work is centred on the women under their care (McCourt *et al.*, 2006). These midwives provide care whatever that choice of setting (hospital, home, birthing centre) and regardless of risk classification and outcome - in other words, the midwife will follow the woman. Each individual midwife in the group will be the primary carer for a designated number of women *pro rata* of her contracted hours of work and will assume secondary responsibility for the designated caseload of the 'buddy' midwife colleague. This way the women know two midwives within the group very well and continuity of carer is provided whilst making allowances for the midwives' private lives.

Hierarchy of Continuity: McCourt *et al.* (2006) highlight the confusion that exists in attempting to define continuity of care or continuity of carer. As seen in Chapter 2, these terms are almost interchangeable in the literature, but these authors stress that unless "the mechanisms through which care delivered over time improves outcomes" is understood, continuity will continue to be misunderstood. To this effect, they have turned to the work of Saultz (2003) that provides a hierarchical definition of continuity of care.

Hierarchical definition of continuity of care

Informational: medical and social information about each woman that is available to healthcare professionals and the systematic process that allows for the sharing of relevant information.

Longitudinal: each woman has a 'place' where most of her care is provided by an organised team of providers. This team assumes responsibility for coordinating all aspects of care.

Interpersonal: an ongoing relationship exists between each woman and a midwife. A trusting relationship develops and when this personal midwife is not available arrangements are made to ensure that longitudinal continuity occurs (adapted from Saultz, 2003).

Thus, continuity of care means that there is shared organisation and values that allow for the provision of care by a team of midwives. Continuity of carer means that midwives have the freedom to organise their practice to allow for the development of a trusting relationship with the women in their care.

Chapter 2

Review of the Literature

Introduction

In order to provide a context for this study and to allow the author to explore the relationships between this study and the existing research literature, this chapter will examine the existing literature on the organisation of midwifery services. In particular, it will explore those research studies which have focused on this topic and on teamwork in midwifery. It also discusses some of the most important policy documents for midwifery services produced in the last 15 years and considers several studies which have been carried out by social scientists working in other areas of organisational studies which can be applied to the organisation of midwifery care.

The chapter moves first to a discussion of the terms 'continuity of care' and 'continuity of carer', and then to a group of studies which have explored the particular ways in which the delivery of midwifery care within the hospital, and thus shaped by medical and nursing models, might be altered by or shaped in an attempt to deliver continuity of care or continuity of carer. A significant feature of this section is that a number of these early studies report that where opportunities for improved contact with women is offered, whether in terms of 'continuity of care' or 'continuity of carer', both women and midwives report more positive experiences. Within the present study, the opportunity is afforded to explore in depth the ways in which these positive experiences for both women and midwives are constructed. The chapter then moves on to explore in more depth the reasons for the fragmentary nature of care within hospitals, and highlights the way in which the 'Changing Childbirth' policy (DoH, 1993) offered increased opportunities for midwives to reclaim autonomy.

Next, the chapter turns to a discussion of team midwifery and the difficulties around establishing a clear definition of this term. A number of studies of team midwifery are reviewed and a discussion of team working in general is included. A model of teamwork, which will inform the description and analysis undertaken in this study, is identified. Finally, the chapter moves to a discussion of ethnography and ethnographic work in midwifery, noting the important similarities between the findings of those studies and the present study.

The very first midwifery study that explored the way in which service delivery was organised and the impact the organisation of services had on 'continuity of care', was Flint *et al.* (1989). This study was undertaken by midwives. Flint *et al.* (1989) undertook a ground-breaking randomised control trial (RCT) of team midwifery designed to specifically test the concept of continuity of care. A team of four midwives provided the majority of the care throughout the pregnancy for 503 low risk women and compared the outcomes with 498 low risk women receiving standard hospital care. Women were randomly allocated to either group. The care given by the team was found to be associated with a greater continuity of carer and the women found it very acceptable. They spent less time in the antenatal clinic and felt more satisfied and better able and prepared to discuss problems. Mothers who had team care had fewer obstetric interventions, though neonatal outcomes were similar in both groups. This study suggested that the organisation of care could have cost implications for the service, such as reduced use of pharmacological pain relief and fewer instrumental deliveries.

This was the first RCT undertaken by midwives that focused on continuity of carer. This was a credible piece of research, well thought out and undertaken; incorporating

well considered variables and because RCTs conform well to 'scientific' models commonly used within medicine, the study was able to make a significant impact on the medical community. Its publication catapulted the midwifery profession into a debate for re-organisation of the maternity services. The study seems to have been the impetus for government action. One important impact of this report is that midwifery research initiated the debate and influenced government action.

Other factors, which combined with the findings of Flint *et al.*'s research, were growing consumer dissatisfaction with the lack of choice in the maternity services and professional unrest at the fragmented nature of the service. This combination of factors led the government to appoint an all-party Health Committee in 1991, chaired by Mr. Nicholas Winterton. The Report of the Health Committee (the Winterton Report), following their inquiry into the maternity services, was published on 4 March 1992 (DoH, 1992).

The growing importance afforded to the voice of the consumer of the service was clear in this development, and the Winterton Report (DoH, 1992) reflects this in its general thrust. The Select Committee concluded that a 'medical model of care' should no longer drive the service. Women should be given unbiased information and an opportunity for choice in the type of maternity care they receive. The government announced in its response to the Select Committee's report that it would set up an 'expert' committee "to review policy on National Health Service [hereafter NHS] Maternity Care, particularly during childbirth and make recommendations" (DoH, 1992, p.2).

The Expert Maternity Group (in response to the Winterton Report) was established in October 1992 under the chairmanship of Lady Cumberlege, Parliamentary

Undersecretary of State for Health, and drew membership from women who used the NHS maternity services and from the professionals who worked in these services. The report of this expert group, 'Changing Childbirth', was published in August 1993. The main thrust of the report (DoH, 1993) was to recommend the provision of continuity of carer and that women using the maternity services should become partners in their care. The midwifery profession attempted to meet this challenge by promoting 'team midwifery' as one form of organisation that offered an enhanced opportunity for continuity of carer.

Definition of terms

The terms 'continuity of care' and 'continuity of carer' are used frequently and very often interchangeably. Newson (1984) makes the point that with the shorter working week, continuity of personnel or carer could not be achieved, only continuity of caring (i.e. underpinned by shared philosophies so that all those in contact with the women provided the 'same care'). Howie (1987) concurs with the opinion that the thirty seven and a half hour working week was a major obstacle in the provision of continuity of carer. Flint *et al.* (1989), however, assert that continuity of carer could be provided by a small team of midwives known to the women, but they did not mention if this was achieved within the thirty seven and a half hour working week. Currell (1990), however, argues that the issue is not continuity of carer but 'unit of care', turning away from the caregivers and focusing on the woman. It was also argued that this focus approximated more closely to individualised care, which overcame the problems of different people contributing to the care of the woman, as all should be following a 'plan of care' which was developed with the mother.

As illustrated above, there is confusion of the terminology when trying to define 'continuity of care' and 'continuity of carer'. Flint (1992) took up this theme when she explained that for many people continuity of care has become synonymous with continuity of advice rather than continuity of personnel. Ball *et al.* (1992) identified a problem of perception of the maternity services in this country. Midwives were seen as people who staff a place such as the antenatal clinic, the labour ward or community. These authors argue that if we move away from the concept of staffing 'places' to the concept of staffing 'women', numbers of staff might conceivably be changed and working patterns become far more flexible. After all, they argue, the title MIDWIFE means 'with woman' and what women really need is for the midwife to be 'with her' wherever she is.

Garcia (1993) states her opinion that continuity of carer is defined as the opportunity granted to the woman to get to know the person or persons who will care for her during her pregnancy and puerperium. This seems a more specific and useful definition. One of the ten Key Indicators of Success identified in the Cumberlege Report (DoH, 1993) was that "75% of women should know the person who will care for them during delivery". There was no consensus, however, on the definition of the concept of 'should know'. Each maternity service used the interpretation that best met its own needs. Variation ranged from only one encounter between midwife and woman to total continuity of carer.

Research concerning continuity of care

Black (1993) highlights the fact that continuity of care has been the focus of much discussion but little research. One exception is the work of Auld (1968) who undertook a small study based on the total patient care concept, which meant that one way

continuity of care had been interpreted on maternity wards was to attempt to allocate a midwife to a woman and to then expect that midwife to deliver all care to that woman while on duty. The organisation of the care provided on the ward was divided into teams. Questionnaires intended to assess satisfaction were given to the participating women and not to other wards, therefore a comparison was not made. Findings from this study indicated that the staff, nonetheless, felt that the scheme meant there was too much responsibility placed on staff midwives and that they could not delegate. Student midwives and part-time staff, however, were very enthusiastic about the scheme. The negative aspects were that Team Leaders practised job allocation within the team framework and it was expensive in staffing terms. The numbers in this study are very small, but its value is the fact that this research was one of the first to attempt to analyse the move away from task allocation forms of work organisation within midwifery and this study has contributed to the debate.

Metcalf (1983) also studied an attempt at changing the work organisation from task orientated to patient allocation. In this small study (120 participants), patient satisfaction with staff and the nature of the midwife-patient relationship were compared for the two systems. In the quasi-experimental research design that examined the process and the outcome, two wards changed to patient allocation. Improvements were made in continuity of care as defined within the study and the mothers commented that they enjoyed having the same midwife caring for them. The reasons given by staff for their preference for patient allocation was that they felt they knew more about the mothers, the teamwork was good and they felt they could plan their work better. This study, though small, seems to build on Auld's work and confirms the trend of the debate that suggests that working in teams was not only feasible but provided enhanced job satisfaction for the midwives.

Watson (1990) studied the provision of continuity of carer throughout pregnancy and the puerperium. She used a survey of fifty mothers cared for by a team of midwives and fifty mothers using the traditional model of midwifery care. This initial survey was followed up by semi-structured interviews. The experimental and controlled groups were matched on a range of demographic and obstetric factors. Watson (1990) was able to demonstrate that there was increased job satisfaction for the midwives in the teams and that the mothers cared for by these midwives reported greater satisfaction than the controls. These women were also able to describe their experiences in a more positive light. However, there was no reported difference in the maternal and neonatal outcomes used in the study. Recommendations arising from this study were that it should be replicated with more teams and for a longer period of time, thus acknowledging its small sample. The criticism here is that the study compared the provision of continuity of carer from a pilot team made up of wholly committed midwives, with care provided by midwives working within a traditional hospital-based model, therefore the job satisfaction element may be said to be affected by bias, since the commitment to teamwork had already been espoused by the midwife participants in the study. However, this aforementioned study's findings resonate importantly with the findings from this thesis, which explain just why a committed team of midwives and the women they care for express more positive experiences than those working within the constraints of hospital routines, and the fragmenting impact those routines can have on care.

Black (1991) undertook research with a different focus, the collegial activity of the midwives rather than continuity of care *per se*. This study was undertaken in a maternity unit where team midwifery had been in operation for a year. Once again this was a very

small study (110 participants). The findings of this research were that midwives felt that the holistic care provided by team midwifery led to a greater rapport with their clients, that they were given more responsibility, that they had the opportunity to practise midwifery more fully and were able to give more individualised care. Once again, this particular research focused on a pilot team and once more the results echo the findings of this thesis.

Although these findings cannot be compared directly (as the purpose of the studies, the methods employed and the organisation and definition of team midwifery were very different), it is still interesting to note the similarities in the views of women and midwives expressed when midwifery is organised in a way which allows increased opportunities for continuity of care, whichever way this is conceived. From the Cambridge study undertaken by Green (1988), 750 women were surveyed and asked about their expectations and experiences. Continuity of carer ranked high in significance in the findings of this study, as it did in the national face-to-face interview study undertaken by MORI's Research Unit for the Expert Maternity Group (Rudat *et al.*, 1993). The sample size in the latter study was greater (1005 women), the questions were open and the women had no pre-set categories to choose from. There are, however, problems in assessing consumers' views and they are to be discussed later in this work.

Hodnett (1993) reviewed trials of continuous social and professional support during labour and birth. The ten trials reviewed have various settings and support persons, but do have a similar element of touch, praise and encouragement. The results demonstrate a reduced rate of intervention for the mother and a higher five minute APGAR score for the neonate. Hodnett (1993) also undertook a meta-analysis of randomised controlled trials, which focused on extra social support during high risk pregnancies. The results

were surprising, in that they demonstrated a lack of success in reducing serious clinical problems.

These studies demonstrate that the issue of continuity of carer is of great importance to women, though they do not often express this sentiment in those terms. Bostock (1993) undertook a study of 23 women using structured interviews and found that women expressed themselves in terms of the joy of seeing a familiar face, the security that a trusting relationship offers and, conversely, the panic experienced when faced with a change of shift and a new midwife to get to know. These are all indicative of the women's desire for continuity of carer. The underlying issue, of enormous importance to the women interviewed, was the establishment of a relationship of mutual trust with the midwife. The importance that the women gave to this process was repeatedly emphasised. This study is a small qualitative piece of research that adds depth of understanding to women's feelings, and once again the findings of this study resonate significantly with the study presented in this thesis.

There are inherent difficulties in analysing consumers' views on the maternity services and the treatment they have received. Women view the experience of their pregnancy with the hindsight of its outcome. Most women are so grateful for a healthy baby that they do not often express the fact that they would not repeat the experience out of choice. For the vast majority, however, motherhood overrides the negative experience and they do return, hiding their fears and anxieties. This should be seen as a failure by the maternity services to give adequate support (Oakley, 1992). Oakley remarked on the professional assumption that the meaning of silence denotes satisfaction, but unfortunately this assumption is also to be found in many other professional fields. It is a fact that complaints and the fear of publicity and/or litigation generate change.

Therefore, the assumption is always present that a lack of complaint means satisfaction. However, Garcia *et al.* state that:

> "Women's reactions to care around the time of birth can affect the way they care for themselves and their baby" (1998, p.4).

Yet most evaluations of 'what women want' for the maternity services are both determined and limited by what the local service has made available (Newburn, 2006). Newburn also highlights that in the 'Changing Childbirth' report (DoH, 1993) there was no discussion on the culture of maternity services, therefore no overview of how the service works and the expectations that may be realistically elicited from it (Newburn, 2006). Unless women have first-hand experience of the local maternity services, they will not know what to expect and thus, what to request or demand. In spite of that, these very women may have developed a sense of loyalty to the service that prevents them from critical analysis of their experiences (Allen *et al.*, 1997). It is, in fact, the women who have moved or have experienced more than one model of care or maternity service, or experienced a hospital and a home birth, that can offer a more rounded overview and comparison of maternity services.

Another crucial component of eliciting women's views of what they want for the local service is the provision of meaningful information. As soon as a woman confirms her pregnancy she is bombarded with an overwhelming amount of information, much of it tailored to the 'middle ground' and which may be inappropriate for some minority groups and the disadvantaged (both social and in reading skills). Personal caseload practice, where continuity is enhanced, gives both the midwife and the woman the opportunity to explore the issue of information sharing. Based on a developing trusting relationship, the woman may feel emboldened to ask questions that are meaningful to her, and the midwife will have the opportunity to tailor the information to meet that

particular need. However, a word of caution is required; midwifery management and supervision need to be involved in ensuring that the systems are in place to guarantee that the information given by midwives is sound, evidence-based and discourages the promulgation of personal philosophies and agendas. Newburn recommends that maternity services should:

> "explore with women and their partners what they want from the service, not just to ask them what they think about what is currently on offer" (2006, p.18).

This represents a seismic shift for most maternity services and it needs to generate a focused approach to open and frank discussion of the provision of maternity services in their broadest terms that are not curtailed by financial and organisational agendas.

Oakley's (1984) opinion is that tacit acceptance of what is already there is generally characteristic of the ideological stance of dominant groups towards oppressed minorities; in this case the medical/midwifery group is the dominant partner in relation to the women they should be caring for. This imbalance of power between women and the people caring for them has many implications, which lead some midwives to question the use of patient questionnaires as evidence of satisfaction with midwifery services. The author will now consider the midwives' viewpoint.

Midwives' perspectives

All women who were practising as midwives at the time of the 1902 Act, and had not undertaken a period of training, were allowed to continue to practise provided that they were on the Role of Midwives and these were known at the time as the '*bona fide* midwives'. In 1916, the length of training was six months with two months remission for trained nurses, then it increased to one year in 1926 with six months remission for

trained nurses. Thus, the midwifery profession allied itself to nursing and absorbed the traditions of nursing (Flint, 1991). Sullivan and Weitz (1988) point out that the move into hospitals did not take childbirth totally out of the hands of midwives. Instead, midwives followed childbirth into hospital. This move proved to be to the detriment of midwives' autonomy, as they incorporated the nursing culture which already existed within hospitals into their profession. As a consequence of this move, their work was clearly brought under the umbrella of the hospitals' dominant medical paradigm of childbirth.

It is of interest to note the work of Menzies, who published a report in 1970 on the research she had undertaken at a London teaching hospital to develop new methods of organising care. The functioning of social systems as a defence against anxiety received a mixed response. Menzies (1970) states that the accepted rationale for the method of task orientated care was to protect the nurse by preventing the development of a relationship with her patients. As the relationship between nurse and patient was seen as a potential source of anxiety, the organisation was seen as seeking to protect nurses from this anxiety by preventing the development of the relationship. The nurse was expected to perform a range of tasks on a large number of patients and her contact with an individual was necessarily restricted. Within such a model, the ideal nurse was perceived as detached and could move to work anywhere at short notice. In spite of the span of nearly thirty years since Menzies' report, this rationale still forms part of the management of midwifery care in most hospitals. It is clear that this form of work organisation comes into obvious opposition with values and practices which emphasise the close personal relationship between midwife and woman encapsulated by models of work based on valuing being 'with woman' wherever she might be and whatever her needs might be.

This conflict between values, practices and existing forms of work organisation is recognised by authors such as Miller (1981) and Exworthy and Halford (1999). Miller (1981) looked at the sociological aspects of work and points out that professionals were focused on clients' needs, and it was from the good service provided to their clients that the professional felt validated and gained job satisfaction. In contrast, the NHS as an organisation was focused on hierarchical management with the drive to meet targets and financial agendas. Thus, the professional working in this culture was at odds with attempting to conform to *both* cultures.

The traditional model of midwifery service has a number of inbuilt problems. Midwives are mostly attached to hospitals. Allocation to wards, shifts and rotas limits their flexibility and this confines their opportunities to care for women and babies at the time and to the degree that is most needed. Staff shortages have led to internal rotation, where night and day shifts are fitted in to 'cover' the hospital staffing levels with little regard for the midwives' well-being. Shifts have to be covered, whether there is much work or not. Fluctuations in workload could be best met by a more mobile service in terms of availability of time and location of need. The use of healthcare assistants to provide family type care, in the Dutch model, would assist this process. It would provide practical support for women at home and assist the midwife in the provision of a comprehensive service to the new family. The document 'First Class Delivery' (Audit Commission Report, 1997) comments that some Trusts were in discussions with the view to establishing a specialist role and training for breast feeding advisors: "...this may require investment in the training of breast feeding support workers". Arguably, it could be incorporated into the role of the healthcare assistant.

Some authors have, therefore, suggested that it would make more sense to develop a service where most midwives work in a flexible way, wherever the clients need her care: home, hospital, clinics, delivery suites, operating theatres and/or wards (Ball *et al.*, 1992). This would enable midwives to build a relationship of trust with the women and provide continuity of carer. Thus, midwifery would move away from 'the hospital' to be 'with woman'. Hunter (2002) describes how midwives use a 'with woman' model of care with the emphasis on normal physiology of birth and an individualised approach to care when they are able to work in the community or encouraged to deliver one-to-one care. This contrasts with the 'with institution' model that meets institutional demands and was informed by a medicalised approach to childbirth.

The Midwives' Code of Practice (UKCC, 1994) contains a remit for greater autonomy than nursing. Midwives have a mandate for autonomy enshrined in statute and would like to perceive themselves as autonomous practitioners, but unfortunately, the vast majority of midwives work in hospitals where the structures have been inherited from nursing and midwives are often perceived as obstetric nurses. Hobbs (1993) highlights this issue by declaring her opinion that the concept of autonomous practice does not figure largely within the confines of hospital policy. Many midwives now feel much more comfortable working in a place where medical back-up is constantly available, possibly due to the increased awareness of risk management and the fear of litigation.

Sandall (1996) undertook a study from the social science perspective and comments that changes in the organisation of maternity services could perhaps be better explained from the sociological literature on occupations and professions. Authors such as Weitz (1987) trace the history and development of midwifery, but highlight the influence of feminist writers and women with feminist perspectives who have entered midwifery. Sandall

(1996), however, states that 'Changing Childbirth' (DoH, 1993) challenged three sets of power relations. These were the managerial hierarchical relationships within the NHS, the inter-occupational relationship between doctors and midwives, and the licensing controls. Sandall cites the following examples:

> "1) By providing continuity of care to all women in a geographical defined area regardless of risk categorization (House of Commons, 1992) they challenge the traditional 'risk' demarcationary boundaries of the medical profession.
>
> 2) By proposing that midwives set up in their own practices and contract their labour to the new purchaser health authorities, they challenge the managerial and medical domination within the NHS (Leap, 1994).
>
> 3) By challenging the link with nursing by demanding separate legislation for midwives (Cronk, 1990), abolishing nursing as a prerequisite in midwifery training, (Alexander, 1993) and by negotiation separate pay agreements from nurses, (Allison, 1995)"
> (Sandall, 1996, p.221).

Thus, argues Sandall (1996), the ideology of continuity of care systems reclaimed the practice of midwifery. This, in turn, was supported by education that was based at university level and was generating a discrete 'body of midwifery knowledge' and expertise. This higher education was seen as legitimising an equal partnership between women and their midwives.

Team midwifery

When studying the literature on team midwifery, the conclusion was that the term 'team midwifery' had a variety of interpretations. There were three main models of team midwifery identified: teams providing hospital care only, those providing community care only and those providing care in the hospital and the community. The concept of continuity of carer implies that the majority of care and advice was provided by one midwife. This, in turn, implies the integration of hospital and community services

(Stock and Wraight, 1993). The rationale for team midwifery was an improved opportunity to achieve continuity of carer. This was best achieved by matching a small team of midwives to a defined group of women in order to provide total care from early pregnancy through delivery and including the puerperium.

Page (1995) argues that midwives holding an individual caseload, responsible for a small number of women regardless of whether they are low or high risk, should group together and use the name of Midwifery Group Practice. She states that:

> "I advocate group practice rather than team midwifery. The main difference between the two types of practice is that group practice involves a small number of midwives who carry a caseload, whereas team midwifery can involve much larger numbers of midwives and may be purely hospital based. Group practice moves forward from the idea of team midwifery in that it implies the organization of a practice, rather than simply a shift of ward-based or community based staffing. This is a fundamental difference" (Page, 1995, p.13).

NHS maternity units should be organised in such a way that care would be provided on an equitable basis, because they form part of the essential services to be provided for the population. Stock and Wraight (1993) argue that continuity has an associated cost to be borne either by the service as a whole or by individual midwives. These authors found that it has been suggested that in order to provide a 'named midwife' service, each midwife would either have a smaller workload in terms of numbers and complexity than the current national average workload (which stands at an average of 36.1 women per midwife in medium to large consultant units) or, alternatively, would have to work longer hours and be highly flexible.

The Cumberlege Report (DoH, 1993) notes that private MGPs demonstrate a high quality practice and that they achieve the most complete continuity of carer, but their costs may be higher than the present NHS arrangements. Stock and Wraight (1993)

argue that, prior to the internal market model, all costs in the NHS were not identified as individual items, therefore making it difficult to accurately prove a comparison in costs.

The evaluation of the Albany Midwifery Group Practice (Albany MGP), undertaken by Sandall *et al.* (2001), provided an insight into how a group of independent midwives were able to demonstrate the viability of this self-employed group. The midwives in the Albany MGP had worked in this format since 1997. Their predecessor was the South East London Midwifery Practice, founded in 1994 as a self-employed and self-managed group of independent midwives. Their aim was to:

> "...provide continuity of midwifery care (antenatally, during the intrapartum period and postnatally) with known midwives to local women with a policy of targeting certain groups, and promoting equity of access, thereby meeting the objectives of *'Changing Childbirth'*" (Sandall *et al.*, 2001, p.9).

The Albany MGP was the very first group of community-based independent midwives in the country to obtain a contract with a local Health Authority with NHS funding. They were selected as a pilot MGP site by the regional NHS Executive and this in turn facilitated the contracting process (Allen *et al.*, 1997). This midwifery practice was self-managed and held weekly meetings to address the business agenda with the input of an advisory group consisting of 50% users and 50% professionals with 'relevant expertise'. Statutory supervision of midwives was provided by the supervisors at local hospitals serving the area.

This model of midwifery care proved to be very popular with both the women it served and the midwives working within it. This midwifery practice soon became nationally and internationally acclaimed, as the concept of an MGP contracting into the NHS was ground-breaking. But, in spite of its acclamation and success, funding became a major concern throughout the early years. Eventually the Albany MGP sub-contracted their

services to the King's College Hospital NHS Trust in 1997. The concluding comments from the evaluation study are that the Albany MGP was very successful in achieving "normality in pregnancy and birth". One of the key objectives of the Trust was to improve childbirth outcomes in very deprived groups of women and the Albany practice had achieved this criterion (Sandall *et al.*, 2001).

The Albany practice aimed to provide continuity of carer and this was achieved very successfully, as the vast majority of their women were attended throughout by their primary midwife or her 'buddy' colleague. The report states that more Albany women knew how to access their midwife and did so. The report, however, comments that without additional analysis of the cost-effectiveness of running such a model alongside the NHS framework, it is difficult to comment if this model is financially viable. The Albany practice has undoubtedly served as a model for other MGPs (for example, the Abbey Midwifery Group Practice [Abbey MGP]) to emulate. The report comments that the success of the Albany MGP is that the midwives:

> "...were more able to devote time to providing midwifery care because of the administrative support provided by the practice manager. As more midwives move out into midwifery group practices in the community, this level of support to the Albany practice should be recognised" (Sandall *et al.*, 2001, p.82).

The Albany practice proved that the MGP model was workable within the NHS framework. They also proved that the caseload of the group need not be restricted or selective in any way and that both the women and midwives enjoyed working this model.

Currell (1993), however, expresses concern that in units where only some of the women are cared for by team midwives, some clients would receive a better service than others. This concern is also highlighted by Stock and Wraight (1993). This situation would be

resolved by implementing fully integrated teams, where the midwife follows the woman regardless of the anticipated outcome. The service thus organised could cater for *all* women to be cared for by a small team of midwives, regardless of their pregnancy risk factors. Therefore, if a woman needed to come under obstetric care, her midwife would accompany her to the clinic, not merely as an escort but to contribute her expert knowledge of her client. She would conduct the delivery of the baby, or be present supporting the woman if the mode of delivery should be instrumental or surgical. This midwife would then continue the care throughout the puerperium. This is described as 'case holding' and authors such as Page (1995) and Stevens (2003) advocate this system.

Stevens (2003) undertook an ethnographic study of caseload midwifery evaluating the one-to-one midwifery practice. She recommends case holding as a workable option for midwives. Midwives would no longer staff hospitals (apart from providing a core team for emergencies or clinical expertise and support) but would follow the woman. Stevens reports that midwives view caseload practice as:

> "...a fundamental change to the meaning of midwifery for them and the mothers they care for, working as members of a team in which the contribution of all parties, including the mother, are valued equally" (2003, p.322).

Stevens (2003) acknowledges that her study forms part of a wider evaluation of the caseload model of midwifery practice (McCourt and Page, 1996; Beake *et al.*, 2001), and concludes that this midwifery model was a viable option for the maternity services and held benefits for both mothers and midwives. This study was a valuable contribution, not only as part of a multifaceted review of the service, but also because the method of choice was ethnography that allowed for a variety of data collection methods. The added positive to Stevens' (2003) work was that the data was collected

over a 46 month period, thus ensuring a longitudinal view of the data. Therefore, this work echoes the choice of method and timeframes for this thesis.

The possible problems (as discussed in Chapters 6 and 7) with this model could be the development of a 'them' and 'us' attitude between teams and core staff, and between the teams themselves. This phenomenon was described by Hunter (2002) as a process of intra-occupational boundary maintenance that was generated by the mismatch of professional ideals and the reality of working in organisational structures. In this system, which allows the midwife to accompany the women throughout pregnancy and the puerperium, the relationship between the women and midwives would be allowed to develop, though for some there was a risk that this relationship may become too intense. As discussed above, the hospital system was perceived to offer 'protection' from such intense relationships. However, with good support from managers and supervisors of midwives providing an understanding of therapeutic relationships, the midwife-mother relationship can flourish within safe boundaries.

A number of teams have seen the introduction of a 'Team Leader' to their structure. This is perceived by most contributors to the literature as a compromise in order to fit team midwifery into the present hierarchical midwifery structure (to be discussed in Chapter 6).

Implications for midwives

Stock and Wraight (1993) were the first and, at that time, only researchers to be commissioned (by the Institute of Manpower Services) to undertake an in-depth study of the implications for midwives of developing continuity of carer in the maternity services. The Institute of Manpower Services (IMS) and the Royal College of Midwives (RCM) identified a list of units known to operate team midwifery or continuity

schemes. Seven of the teams were approached to participate in this study. Five were chosen on the basis of intrinsic interest; they typified a variety of approaches intended to enhance continuity of care, and each had pursued this goal in a different way. These units served large populations, both urban and rural. The IMS researchers visited each of the five units and undertook separate interviews with midwifery managers and groups of midwives. They reported that the main incentive for midwives to express a desire to join midwifery teams was the ability to become an independent practitioner providing care for a defined caseload, in control of their own workload and responsible for their own time, within a team environment.

Generally, midwives spoke of increased opportunities to use all their skills and greater prospects for self-development. They said that working as a part of a team, rather than in a fragmented service, provided the opportunity to learn from their colleagues and enabled the team as a whole to identify their own training needs to suit their caseloads. The consensus among midwives spoken to in this study, was that working in teams resulted in increased job satisfaction. They stated this was due to a greater utilisation of their skills, higher levels of autonomy, the feeling that they really were able to work as independent midwives and the view that team midwifery delivered better care as a consequence. This study was able to focus on the five maternity units that had re-organised totally into teams; therefore, the conclusions carried more weight due to the inclusion of all staff working at those units. Unfortunately, the report does not provide the reader with the composition of the groups of midwives interviewed.

In this study, Stock and Wraight (1993) were also able to examine the situation of the midwives remaining as a 'core team' to provide support to the teams and the hospital. Retaining a group of midwives to continue to work in the hospital to cover all

eventualities was a sound concept and would cater for personnel who did not wish to belong to teams or could not drive. This, however, could give rise to 'two tiers' of midwives, with different pay scales and different opportunities for development. Midwives in some units spoke of 'them' and 'us' attitudes developing (Stock and Wraight, 1993; Kirkham, 1999; Hunter, 2002).

Leap (1994) undertook a postal survey of midwives' feelings towards team midwifery (100 respondents from a potential midwife population of 34,000) and some of the points raised were that working in small groups has meant that the midwives are more supportive towards each other and have helped in practical ways to support members of the team who experienced illness, bereavement or other personal or work related problems. The midwives found that they were able to reflect upon and evaluate their practice in a safe and supportive environment. These midwives felt that they were able to take ownership of their practice, and this in turn enabled them to become more assertive (discussed in Chapters 7 and 8). Once again, this was a very small sample that has contributed well to the debate and these findings are reflected in this thesis.

Team midwifery could not be seen as a panacea for the maternity services. It did enhance midwives' professional self-esteem, but it required midwives to change their working culture. Flexible working patterns were not easy to adapt to and, for many midwives, difficulties with childcare arrangements arose. Stock and Wraight (1993) identified that midwives felt that the inconvenience of a flexible working pattern was an acceptable trade-off for enhanced job satisfaction. Currell (1993) warns that midwives need to be very assertive in negotiating workloads, because in the present climate of litigation there is no room or sympathy for an over-committed, tired midwife. Present-day developing technology and risk management philosophies demand constant

vigilance and prompt decision-making. Careful observance of good management of change, but above all, caring and supportive management, would be essential requirements for good team midwifery practice.

The process of change to team midwifery represented a large organisational and cultural change for midwifery units. The profession had to ensure that the new structures were based on a realistic view of the professional needs and desires of the midwives, and not a compromise within existing management structures. Stock and Wraight (1993) conclude that team midwifery cannot be delivered on the cheap, or with uncommitted staff. However, in the present financial climate there are great constraints placed on midwifery managers to achieve the impossible.

Many midwifery units had set up pilot studies; they had produced the evidence from audit and now faced failing to move to a complete re-organisation to team midwifery due to financial constraints. These units were, in effect, operating a two tier service. There would always be arguments about the best use of resources, the need to balance quality of care with quantity of care, and the imperative to treat all women and staff equally.

Adding to the debate in the latter 1980s and early 1990s, Hunt (1995) undertook an ethnographic study of two labour wards. These two maternity units were typical examples of the provision of maternity care at that time, where 98% of women gave birth in NHS hospitals. There was no continuity of carer provided under this system. Hunt (1995) provides an in-depth study of the system at work, its effects on the women that use it and the midwives who work within it. Hunt's (1995) study provided the midwife with challenging food for thought and the opportunity to reflect not only on

personal practice, but the system that defines it. The use of an ethnographic approach offers the opportunity to study health professionals in the reality of their work environment, as evidenced in this thesis.

Kirkham (1992) describes ethnography as "...a method used to study the social world of midwifery in its natural state, as it happens". Hunt (1995) observed midwives at work.[5] She adopted the non-participant stance and described midwives at work on the labour wards of two maternity units. This method allowed Hunt (1995) to 'tell it as it really is'. The use of questionnaires and interviews only allowed for personal recollection of events. Observation allowed for the description of reality as perceived by the observer, who attempted to provide a description, as far as possible, uncoloured by personal stake or interest.

Hunt (1995) observed how some midwives spoke to their clients in a demeaning and patronising way as part of the admission process. Had a questionnaire, discussion or interview elicited information about these processes, it was very likely that this fact would not be admitted and these aspects of a midwifery culture would have remained invisible and undescribed. Unless negative as well as positive aspects of behaviour are recognised and described, it is impossible to understand and attempt to modify them.

In order to add a further dimension to plain observation, the researcher may use the protagonist's own view or perspective, but the observation of events stands as the method of choice to comprehend the reality of midwives' work. Hunter (2002) used semi-participant observation, aided by focus groups and interviews. Survey methods could only offer superficial information on women's experiences and midwives'

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[5] Hunt (1995) used ethnography as her chosen method to comment on the 'reality' of midwives' work.

working practices. Therefore, in order to gain an in-depth understanding of such issues, qualitative methods, in particular those which include an element of observation, needed to be utilised.

The benefits to midwives of team working are also apparent from the work of Sandall (1996), who undertook a study of occupational burnout in midwives working with the team concept. She found that that there was a clear relationship between high autonomy at work and lower levels of burnout "which predictably reflects findings in the occupational stress literature" (Sandall, 1996, p.8). This led her to conclude that:

> "...a higher scope of practice is also associated with lower levels of burnout, so greater clinical responsibilities does not necessarily lead to higher levels of burnout" (Sandall, 1996, p.15).

The following areas do, however, demonstrate a clear relationship between working, occupational stress and burnout: lack of control over work load, working within a team that has a large number of members, and conflicts with management (Sandall, 1996). Eight hundred midwives participated in this research, therefore the findings can be used in good measure to inform professional knowledge and management. Sandall's (1996) study has particular relevance to the findings of this study, which will be explored in Chapters 6, 7 and 8.

Green *et al.* (1998) produced a report that would provide evidence for decision-makers in the NHS on the organisation of midwifery services. They undertook to describe, compare and assess the available schemes of the day. One of these has already been mentioned above, the 'know your midwife' scheme (Flint *et al.*, 1989). The following were the remainder of the projects considered by these authors.

Home-from-home scheme

This was a project set up in Leicester as a joint collaborative venture between midwives and obstetricians. It provided antenatal care and labour, but not postnatal care. The midwives working in this scheme volunteered and all were previously working in the hospital. Postnatal care was provided in the 'traditional' way, with a ward staffed by hospital midwives and, once home, care was provided by community midwives. Thus, no overall increase of expenditure was incurred. Three delivery rooms adjacent to the labour ward were decorated with 'homely' décor and furnishings. Midwives worked a three shift per day pattern and undertook no on-calls. Only women deemed to be 'low risk' were accepted for the scheme. This scheme did not provide continuity of carer, but demonstrated that the women were less likely to have an epidural and more likely to use 'Entonox' only for pain relief. They were also able to demonstrate that the women cared for in the scheme were less likely to have an episiotomy. Green *et al.* (1998) highlighted the difficulties in interpreting the different impacts on outcomes of a different way of providing care. Hodnett (1997), however, affirms that we know that women do better and have better outcomes in labour if they are relaxed, confident and have the presence of a supportive person. This study demonstrated that the organisation of midwifery services remained pretty much the same, but some of the environments and expectations of midwives and women included in the scheme were different, thus possibly influencing outcomes (Green *et al.*, 1998).

Aberdeen Midwives

This system provided midwifery only intrapartum care, in a separate midwifery-managed delivery unit only 20 yards away from the consultant unit. The aim was to provide a homely environment and a care philosophy of minimal intervention. Hospital midwives were allocated from the labour ward on each shift to work in the unit. This

scheme admitted low risk women only and was no more than an attempt to make the birthing environment for some women more homely (Green *et al.*, 1998).

Glasgow Development Unit (MDU)

The Glasgow MDU was a midwifery-managed unit within the Glasgow Royal Infirmary. It was not a physically separate unit, but midwives working for the MDU cared for low risk women within a geographical catchment that contained a very deprived area of the city. Each midwife managed a personal caseload throughout pregnancy, intrapartum and postnatal. These midwives had direct access to senior doctors without the necessity of referring to the Senior House Officer. They did not use an on-call facility, but designed a 75 hour (fortnight) self-rostered rotation to cover all shifts. It proved difficult for the authors to draw conclusions in this comparative study when so many aspects of the maternity services had undergone simultaneous changes (Green *et al.*, 1998).

West Essex

The entire health district was covered by seven teams of midwives consisting of seven whole time equivalent midwives per team. The teams were hospital-based or community-based with hospital core staff. There was a team caseload, but not an individual midwife's caseload. If more than one woman from the team's caseload was in labour, they would be cared for by the core staff. Duty rosters were different for each team, but a common element was a period of on-call for the labour ward. No conclusions could be drawn, as too many parameters had been altered at the same time (Green *et al.* 1998).

Not all projects generated as a result of 'Changing Childbirth' (DoH, 1993) were included in this report, because a vast number of these undertook an 'in house' evaluation that did not include a comparison group. Another point highlighted was that "very few studies have looked at the views of midwives who had left a scheme" (Green *et al.*, 1998, p.132). They conclude that:

> "...it is possible that the higher the job satisfaction gained by the midwife, the more likely she is to accept the intrusion of the job into her personal life but this is not to say that this intrusion is an element of job satisfaction" (Green *et al.*, 1998, p.132).

This important point was illuminated further by the experience of the midwives of the Abbey MGP (Chapters 6, 7 and 8). They appear to resent the intrusion of the job into their personal lives, unless it can clearly be managed in a way which does not disrupt and damage those areas of their lives.

Working in teams - theoretical insights

As described above, working in teams can mean different things to different people. For the purposes of this study, the author has adhered to the definition from Belbin (1981) that, in its simplicity, states that teams are a group of people working together. Authors such as Belbin (1981) and Tuckman (1965) have developed theories that describe the most effective team. Tuckman (1965) was the first, and his seminal work has influenced subsequent authors. In searching the literature for other authors and theories on the development of teams, the author found that Tuckman's and Belbin's thoughts are the pillars of the theory, complementing each other and quoted by subsequent authors as the foundation of their own theory development. Belbin (1981) set out a series of tests that would analyse the working 'personality' of each individual member of the team, and identified an 'ideal type' of team that would work better and more effectively. Belbin

(1981) states that the contribution of each individual working in a team was enhanced by the presence of the other team members.

Belbin's theory, however, was not applied to the selection process for the Abbey midwives. The midwives chosen for the Abbey MGP were originally selected according to their home addresses. With time and experience, the local Trust has not applied the same criteria for new members joining the team. Thus, the group has moved away from this original selection criterion. This study demonstrates how the author's observations have led her to describe just how the Abbey midwives developed as a team. They have moved along a continuum that supports the theory developed by Tuckman (1965).

Team development

When the individuals selected to form a team come together, according to Tuckman (1965), they progress in their development along a continuum from the first phase of 'forming' through 'storming', 'norming' and 'performing'. A brief description of each phase follows:

Table 2.1: Tuckman's four elements of group development

Forming	Storming	Norming	Performing
Introduction of team members. Stage of transition from individuals to team members.	Team members will have different opinions as to how the team should operate. The best teams will understand the conflict, actively listen to each other and negotiate a way forward. Other teams may disintegrate.	Team members find a common working method. They are able to reconcile their own opinions with the greater need of the team.	The emphasis is now to achieve team goals. Relationships are settled and loyalty develops. The team is able to manage complex tasks and manage change.

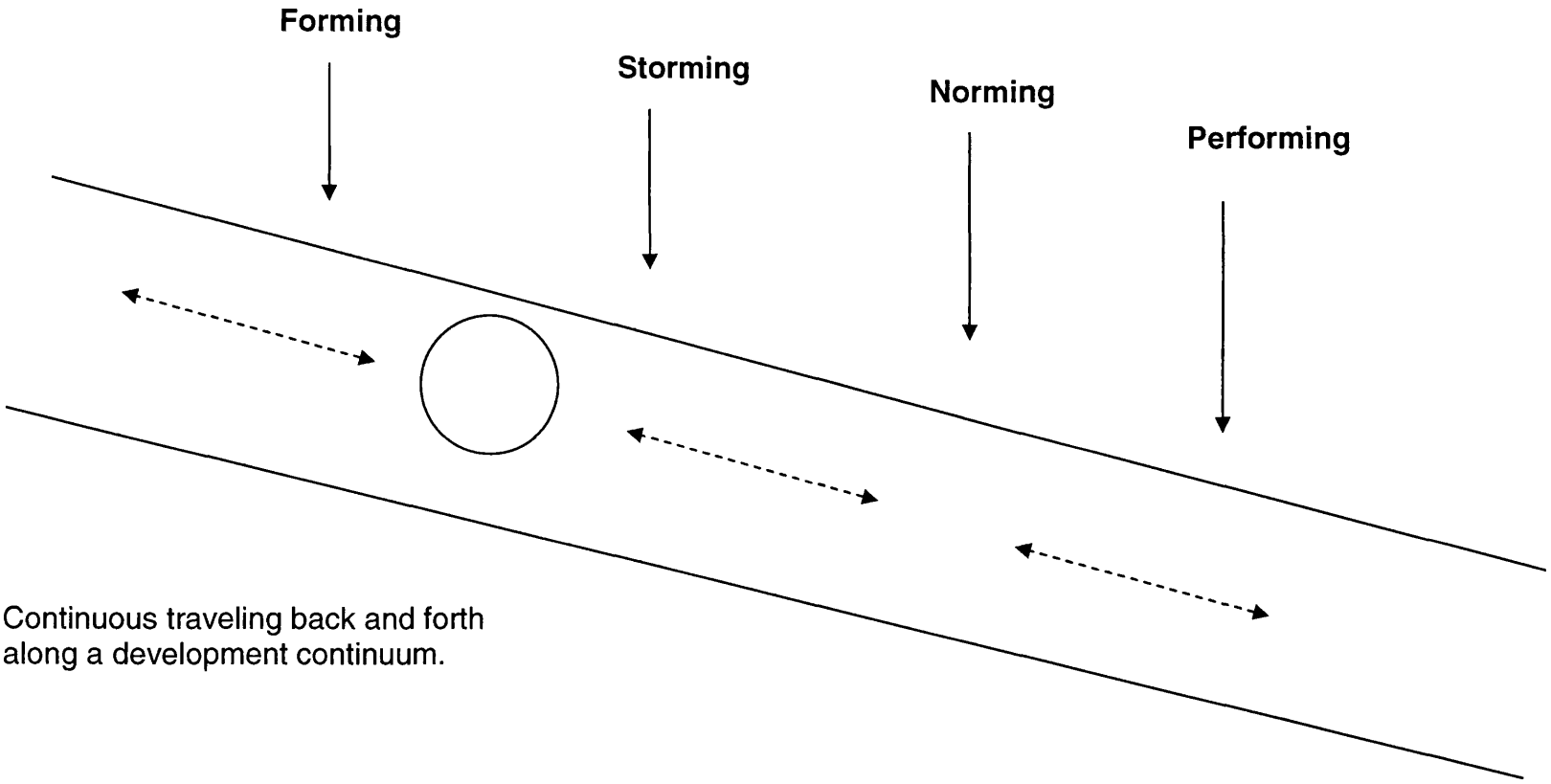
Tuckman (1965) describes the theory of group development. As mentioned above, the model he developed describes a group progressing along a continuum that contains four distinct elements. Figure 2.1 shows a conceptual map of the theory that comprises of a ball moving backwards and forwards along a road, never still, constantly moving from one end to the other, moving through all stages.

Tuckman (1977) later added a fifth stage. He called this last stage 'adjourning'. This last stage describes the break-up of the group with its purpose fulfilled. Tuckman (1977) describes how some members of the team may feel a sense of insecurity or threat from this change, particularly if members of the group have been very close and bonded well as a team. However, for the purposes of this study, the author will not consider this later addendum to Tuckman's (1965) theory, as the Abbey MGP was now firmly established within the local maternity services.

The first of Tuckman's (1965) stages, 'forming', was characterised by assembling the group with a clear purpose. Throughout this stage, the individual members of the group would seek to define clear roles and responsibilities within the group. Blair uses more vernacular language when describing the 'forming' stage:

> "Forming is the stage when the group first comes together. Everybody is very polite and dull. Conflict is seldom voiced directly, mainly personal and definitely destructive. Since the grouping is new; the individuals will be guarded in their own opinions and generally reserved" (Blair, 2000, p.3).

Figure 2.1: Conceptual map of team development



Tuckman (1965), in his model of group development, described a second stage that was dubbed 'storming'. This was characterised by challenges to authority, confrontation with and from leadership, and conflicts among group members. Tuckman (1965) described the fact that the development process is not a defined move from category to category, but is the fluid movement of a group along a continuum that, from time to time, may mean a return to the 'forming' stage as group membership changes or a new 'norming' stage as the group gets complacent and needs new direction. It was also observed during this study that more than one stage might be in progress at any one time during the evolution of the team (these issues will be discussed in more detail in Chapters 6 and 7 of this thesis). Blair has attempted to define groups in the work context thus:

> "...when people work in groups, there are two quite separate issues involved. The first is the *task* and the problems involved in getting the job done. Frequently this is the only issue which the group considers. The second is the *process* of the group work itself: the mechanisms by which the group acts as a unit and not as a loose rabble" (Blair, 2000, p.2).

Blair (2000) continued by saying that groups are particularly good at combining talents and providing innovative solutions that have an advantage over individuals confronting the same challenges. One aspect of the analysis which was undertaken in this study was to explore the ways in which the development of the team (the Abbey MGP), which emerged during ethnographic research, correspond with Tuckman's model of team development (this is explained in Chapters 6 and 7 of this thesis). Table 2.2 demonstrates the time line of the Abbey midwives' development along Tuckman's continuum.

Table 2.2: Abbey MGP. Time line for Tuckman's team development theory

Forming	Storming	Norming	Performing
Introduction of team members. Stage of transition from individuals to team members.	Team members will have different opinions as to how the team should operate. The best teams will understand the conflict, actively listen to each other and negotiate a way.	Team members find a common working method. They are able to reconcile their own opinions with the greater need of the team.	The emphasis is now to achieve team goals. Relationships are settled and loyalty develops. The team is able to manage complex tasks and manage change.
Setting up the team (year 1). Search for identity (year 1). Finding a place - Birthing Centre (year 1). Flexible working (year 1).	Changes to the allocation of work (year 2). Finding autonomy (year 2). Confirming their role (years 2-3-4-5…). Negotiating holidays (years 1-2). Group Leader role (year 2).	Group leader role changes (year 3). Changes to the allocation of work (year 3). New staff join (years 2-3). Changes in responsibilities (years 2-3-4-5…).	Coping with outside threat (year 3). Group relationships (years 1-2-3-4-5…). Loyalty (sickness) (years 2-3-4-5…).
G r o u p r e l a t i o n s h i p s c o n t i n u o s l y e v o l v i n g			

Midwifery culture

Only a few studies have been specifically undertaken on this subject (Kirkham, 1999; Leap, 1997; Hadiken and O'Driscoll, 2000). The latter describe the current culture in midwifery as a 'bullying culture'. Leap (1997) states that 'horizontal violence' is a common characteristic of an oppressed group. Kirkham (1999), however, argues that working in the NHS means that midwives have become accustomed to accepting many changes, in particular medical changes. This, in turn, generates an accustomed response and a sense of belonging to a group which censors deviants. As the author shall show in Chapters 6 and 7 of this study, these insights have particular relevance for the relationships observed between hospital midwives and the midwives of the Abbey MGP who form the focus of this study. Hunter's study demonstrates the role that ideological divisions play in these circumstances, describing how midwives:

> "...constructed boundaries related to their beliefs about good practice, using different strategies to make territorial claims" (Hunter, 2000, p.5).

In fact, Hunter expresses the idea that there is not 'a midwifery culture', but for many it is a spectrum where:

> "...midwives adopt different positions along this continuum that reflect their differing ideologies, resulting in an occupational culture characterized by division and distrust" (Hunter, 2000, p.7).

It was, therefore, not surprising to find that a 'them' and 'us' divide was observed, which is described in this study (see Chapters 6 and 7).

Policy

'Changing Childbirth' (DoH, 1993) became government policy amid professional furore at the lack of central funding to implement the changes. Therefore, the vast majority of Trusts opted to use pilot teams before committing to the extra expense. This was the case for the Trust involved in this study. Thus, the Abbey midwives found themselves as the implementers of the 'Changing Childbirth' (DoH, 1993) policy. They developed and evolved the concepts expressed in the policy document but, as argued by Lipsky:

> "the decisions of street-level bureaucrats, the routines they establish and the devices they invent to cope with uncertainties and work pressures, effectively *become* the public policies they carry out" (1983, p.12).

Lipsky (1983) defines street-level bureaucrats as the individuals who work in the public services. He continues to explain that from the outset street-level bureaucrats are individuals who have a commitment to service, yet the very nature of this type of work is often in conflict with the ideals of their profession. Lipsky highlights that a street-level bureaucrat prefers to take account of the individual's needs, but the organisation he/she works for focuses on equity of service and resources for the entire population with scant attention to the individual. Lipsky develops his argument by describing how street-level bureaucrats become policy makers. He states that:

> "the policy making roles of the street-level bureaucrats are built upon two interrelated facets of their positions: relatively high degrees of discretion and relative autonomy from organizational authority" (Lipsky, 1983, p.13).

In Chapters 6 and 7 of this study the author will describe how moving out of the hospital environment gave the Abbey midwives 'relative autonomy' and 'high degrees of discretion', which were used by them to develop a policy of individualised maternity

care. In these chapters, the author will explore the relevance of Lipsky's work for midwifery practice.

Birth Centres

In most cases, birth centres have evolved from the original GP units. These maternity units, often geographically away from the main acute unit, remained for many years under the jurisdiction of GPs. Midwives worked in partnership with local GPs and offered a service that cared for low risk women in the local hospital (often the cottage hospital). During the 1990s, GPs withdrew little-by-little from involvement in maternity services. With the changes in GP contracts, they have now withdrawn from intrapartum and postnatal care. Local midwives and women have campaigned in many areas to keep these units open and some have succeeded in developing into Birth Centres[6] or Midwifery Led Units[7] (Barrell and Gillespie, 1990; Coyle *et al.*, 2001; Gottval *et al.*, 2004).

Walsh (2004) undertook an ethnographic study of a free-standing birth centre (FSBC). He set out to examine the culture within this centre, which also included an exploration of the working lives of the staff. The method used for data collection was participant observation and in-depth interviews over a nine month period. This study only involved a small group, but was valid none-the-less, because it provided an insight into the everyday working of the midwifery staff in an FSBC. The findings of this study were that staff expressed high levels of job satisfaction and a sense of fulfilment. The likely explanation given for this was the fact that the majority of staff were only working part-time hours. This allowed individual staff to obtain a very good life-work balance and

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6 The Abbey midwives had their 'base' at the local cottage hospital and designated it as a 'Birthing Centre'.

7 The two local GP Maternity Units have since converted to Midwifery Led Units.

provided the service more flexibility from staff to cover shifts at short notice, if required. Walsh found that the boundaries between work and home were far less rigid, as staff not only took work home but home would come into work, with family members coming in for a chat or to run errands, concluding that:

> "Workers who are able to contribute in a meaningful way to decision-making and therefore have greater autonomy and more control around their working roles, may find these impact on their well-being at home" (Walsh, 2004, p.11).

Walsh also comments on the fact that his study reveals that staff feel much more supported in this environment, with part of this process being that all staff know not only each other very well, but also members of their families. This finding is similar to those discussed in Chapters 6 and 7 here, and this study reaches a similar conclusion about the important beneficial impacts of the 'community of practice' which is established when work colleagues also develop personal relationships. He concludes that "the sense of community and belonging are unprecedented" (Walsh, 2004, p.15).

He also acknowledges that Birth Centres are few in number, but their model of care could be replicated in semi-autonomous teams with the autonomy to control employment hours and flexible working patterns. Walsh also comments that teams should be supported in developing strong interpersonal relationships through the use of regular team building activities. He also comments that one of the most important and challenging aspects that requires addressing is that midwifery management "should be based on trust and transparency rather than surveillance and monitoring" (Walsh, 2004, p.15), a sentiment that is echoed in this study and discussed in Chapters 6 and 7.

Conclusion

This literature review has revealed that the bulk of midwifery research undertaken has been based on survey methods and, in the majority of cases, the samples have been very small. Some small qualitative studies were described, and some of these have generated a greater understanding of women's experiences (Flint, 1992; Bostock, 1993; Walsh, 2004). There has been over-reliance on customer satisfaction feedback, with its inherent problems. Where interviews were used, very little information on participants has been made available, thus rendering comments on the content or findings difficult to challenge.

It is worth highlighting a warning here that care has to be taken in identifying what is meant by the term 'team midwifery', because hospital teams, community teams, caseload holding and MGPs are all similar in that they are described as 'teams', but are very different in their formats, roles and responsibilities. A clear, agreed definition of terms is required. A definition of 'team' which will be used in this study was identified (Belbin, 1981), along with a process of team development (Tuckman, 1965) which may facilitate the description of the process of establishment for the MGPs which form the focus of this study. The author has identified her definitions used in this study and described them in Chapter 1.

In the author's opinion. two main studies stand out. Flint *et al.* (1989) and Hunt (1995). The first because it was designed as a randomised controlled trial and the very first in midwifery undertaken by midwives, measuring outcomes that were relevant to obstetrics and midwifery. This work also initiated the radical review of midwifery practice which resulted in the Cumberlege Report (DoH, 1993).

The second study (Hunt, 1995) is worthy of note because it used ethnography to re-examine the familiar world of everyday midwifery. A familiar world becomes 'invisible' as a consequence of familiarity and it needs a piece of work like this to analyse what so often is taken for granted. This study offers a very different picture of the working lives of midwives in the 1990s. The author, similarly, sought to explore the establishment of two new MGPs using an ethnographic approach in order to enrich current understanding of what teamwork is really like, the contextual features that shape it and the individual experiences of working in this new way. Ethnography allows the author to observe and describe what is really happening as the midwives go about their daily work. This enables the 'telling as it really is out there' and will lead to the exploration of the relationship between context and the individual experiences of team/group working.

The insights of Lipsky (1983), later used by Hunter (2002) to identify some of the dilemmas faced by midwives working within the NHS, are also relevant to this study. A number of other studies (Miller, 1981; Holden and Littlewood, 1991, Mehta, 2000; Walsh, 2004) have identified the ways in which the relationships between home, family members and work (the 'work-life balance') which are possible in any particular context crucially influence the levels of job satisfaction for midwives, and thus the experiences of the women they care for. These will be drawn on to increase understanding of the situation of the midwives who form the focus of this study.

In the next chapter, the author provides the background information for this study.

Chapter 3

History and Background to the Study

Introduction

Since publication of the Winterton (1992) and Cumberlege (1993) reports, the midwifery profession has attempted to embrace the principles contained in these reports by developing working patterns that would provide the one element that both claimed could not be accommodated within the traditional model of service delivery. The missing element that was seen as being of key importance was continuity of carer. In order to provide continuity of carer, the service would have to consider major changes to the working patterns of the day.

As illustrated in the literature review, individual units attempted to devise a local format that would allow the service to provide this element of continuity of carer. During 1994, the maternity service where the author worked undertook an evaluation of the service, recommending that change was required in order to encompass the principles of 'Changing Childbirth' (DoH, 1993), placing the woman at the centre of all planning for the delivery of maternity services in the future. As a preliminary to service re-organisation, the work undertaken by other units across the country was studied so that any common pitfalls could be avoided (as evidenced in Chapter 2 of this study).

Independent Midwives Group Practice

As described in 'Changing Childbirth' (DoH, 1993), the model of midwifery care used by the Independent Midwives Group Practice was highlighted as an example of good

practice to be emulated and adapted by others in order to offer women the kind of maternity service they were requesting. Independent midwives work outside the NHS framework, as independent practitioners. Some have also teamed up to work as a group and set up an independent practice modelling the GP's practice.

The author focused her attention on two examples of this model, the Albany MGP (Sandall *et al.*, 2001) and the one-to-one midwifery practice (Stevens, 2003). Both have been evaluated and found to achieve good outcomes for the mothers and midwives. In the case of the Albany MGP, these midwives work outside the NHS as independent practitioners but have contracted their services to the local NHS Trust (see Chapter 2 for details).

In both examples of midwifery practice, each midwife has an individual caseload[8] (no more than 40 women) for which she is responsible. This ensures that the opportunities for total continuity of carer are enhanced. The women and the midwives that care for them will meet frequently throughout the pregnancy and a trusting relationship between them is given the opportunity to develop (see Chapters 7 and 8). The women meet all members of the group at least twice during the pregnancy, but get to know 'their' named midwife very well. It is acknowledged that midwives do need to have time off and to that effect the on-call system is in place. The midwives pair up and cover each other for days off (or even part of a day), thus giving total flexibility to the practitioner to accommodate both work and personal life. It also allows the women in each 'caseload' to develop a relationship with both of them.

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[8] This is based on the work of Ball and Washbrook (1996), who developed workforce planning for midwifery services. This formula was used by the local maternity services to justify the number of midwives in each team and the size of the geographical area they would work in, to ensure sustainable working.

The women speak very highly of this system as they get to know the midwives (and at least two of them very well) and can rely on being delivered by someone they know, even in the event of leave and/or sickness. This then proves to be a popular choice for women and midwives. In the case of the one-to-one midwifery practice, Stevens (2003) was able to prove that this model can and does function well within the current NHS structure and has a positive outcome. The disadvantage is that this model has **not** been universally adopted and thus maternity services are operating a *de facto* two-tier system dependent on the postal area. In the case of the Albany MGP (Sandall *et al.*, 2001), they have had to follow the GP's model and employ a Practice Manager to take care of the contractual business, so the midwives can concentrate on midwifery. Albany MGP has now 'contracted in' their services to the local NHS hospital (see Chapter 2 for details). These two examples are offered as a contrast to the fragmented and less flexible service in the NHS structure, where the same number of midwives are on duty regardless of workload and choice. Continuity and control are frequently not available to the women who use the service.

Preparation for a change of service

During 1995, the local Head of Midwifery gained some finance from a bid to the Department of Health to undertake a feasibility project that would allow the maternity unit to meet the 'indicators of success' set out in the 'Changing Childbirth' report (DoH, 1993). In order to take this project forward, the author was successful in gaining selection to the post of 'Project Leader for the Changing Childbirth Initiative' for the local maternity services.

The 'indicators of success' (DoH, 1993) state that:

Within 5 years:

1. All women should be entitled to carry their own notes.
2. Every woman should know one midwife who ensures continuity of her midwifery care - the named midwife.
3. At least 30% of women should have their midwife as the lead professional.
4. Every woman should know the lead professional who has a key role in the planning and provision of her care.
5. At least 75% of women should know the person who cares for them during their delivery.
6. Midwives should have direct access to some beds in all maternity units.
7. At least 30% of women delivered in a maternity unit should be admitted under the management of the midwife.
8. The total number of antenatal visits for women with uncomplicated pregnancies should have been reviewed in the light of the available evidence and the RCOG guidelines.
9. All front line ambulances should have a paramedic able to support the midwife who needs to transfer a woman to hospital in an emergency.
10. All women should have access to information about the services available in their locality.

Most of these indicators were felt to be achievable within the existing structure of the service. The traditional model of midwifery care consisted of 'hospital midwives' who provided acute antenatal care, immediate postnatal care, intrapartum care and transitional care for those mothers who wished to stay in hospital whilst their babies

were cared for in the Special Care Baby Unit. Community midwives cared for women, both for antenatal and postnatal care. They seldom undertook intrapartum care in the hospital as the numbers of DOMINO (domiciliary in and out) deliveries was very low at an average of 1.2% of 3500 local births a year. The community midwives also undertook deliveries at home, but they were only a few, constituting only an average of 1% of total local births yearly (national figure for 1995: 1.3% of all births).

The challenge was to consider the feasibility of increasing the staff levels in either setting. Until then, out of the total population of staff (156), 20 worked in the community setting and the remainder worked within the hospital. One of the major challenges in attempting to manage the workforce in midwifery is the unpredictable nature of the workload. The 'peaks and troughs' of the work signify that there are times when staffing levels are not adequate for the volume or critical needs of the clientele, but conversely staff have to remain on duty when there is no client to care for. Thus, consideration was given to the concept of re-organising the workforce and developing a community-based service that would be far more flexible in responding to the vagaries of the workload. This service would also fulfil the one 'key indicator of success' from the 'Changing Childbirth' report that could not achieved in any other way; that 75% of women should be delivered by a professional who is known to them.

The basic concept was that instead of staffing the hospital to cope with the variable work demands, the emphasis would be to allocate a number of women to each midwife. This midwife would be responsible for all aspects of care, including delivery, of her caseload. A small group would remain as core staff in the hospital to assist in emergencies and to care for women who attend the hospital but do not live in the local Trust's catchment area. This would mean that each woman would come to hospital

accompanied by 'her' midwife, thus a more even distribution of workload to workforce could be achieved.

Nationwide, the midwifery profession embraced this concept and some developed 'teams' of midwives that could provide more flexibility in the workforce. There was, however, no standard 'blueprint' for development that maternity units could follow and thus each area developed their own vision of the concept. Variations in the size of the teams and whether they were community- or hospital-based (or a combination of both) were all being tried at the time in various localities with varying success (see Chapter 2 for more detail).

During this time, the author dedicated herself to exploring the literature in order to develop a formula that would provide a long-term sustainable framework that could be proven by a pilot scheme and, only then, risk changing the entire maternity service. This exercise revealed that the successful teams were community-based and had individual caseloads of no more than 40 women for each midwife in one year (Ball and Washbrook, 1996). To ensure that this was indeed achieved, the author obtained a very detailed Ordinance Survey map of the area served by the local maternity services and plotted each individual delivery for the previous year (approximately 3,200). The detail was important so, for each village or town, each street would have the number of maternity deliveries identified. Home deliveries were also identified. This gave the author some idea of the location of the workload. The author was very aware that this was not likely to be entirely accurate in predicting figures for the future as it had to be based on the previous year's figures, but it did give a picture of the areas of dense maternity population.

Another factor that influenced the author's thinking at this time was that the main town in the area was a garrison town. Therefore, the population could change virtually overnight, and so a flexible system based on geographical areas had to be devised. Each geographical patch would contain the appropriate number of maternity cases that would guarantee no more than forty women per midwife per year and, in the case of the garrison estate, this number was reduced in order to cope with possible rapid variations. This patch would be flanked by two patches with some lee-way in their numbers, so that in the event that the number of maternity cases became too numerous for any of the teams to cope, their boundaries could be temporarily moved to accommodate this variation in the workloads.

The area served by the local maternity service is very varied. There is a large rural catchment mostly dedicated to the farming industry (therefore there are villages of various sizes and isolated farmhouses), small towns with new housing estates, an old fashioned market town steeped in rural tradition, the main large town that boasts a very long history and was seeking to obtain city status in the millennium, and finally two coastal towns (one of which is a port and ferry terminal, with both dependent on the tourist industry). The main unit is situated in the largest town and holds both a consultant unit and a GP unit. The two coastal towns, approximately twenty miles away from the main unit, contain small GP units[9] with six and eight postnatal beds respectively.

Another debate that was preoccupying the midwifery profession during this time was the issue of whether the teams of midwives should be GP 'based' or work within a geographical 'patch'. The local GPs were vociferous in demanding that each surgery

[9] At the time of completion and presentation of this thesis, the two coastal units have undergone a development programme and have converted into Midwifery Led Units.

should have its 'own' team of midwives, very much like their 'own' health visitors and district nurses. This was not a feasible option, as the area served by the maternity service is so vast. In the main town alone there are twenty four GP surgeries. The author, therefore, set about proving the non-viability of this concept. She took a detailed map of the town and surrounding areas and identified each maternity case for each surgery and was able to demonstrate that local GPs do not have an identified geographical patch and, therefore, midwives from different teams would be visiting women in the same street, crossing the town and adding unnecessary mileage to the costs of the scheme.

The literature also revealed that the ideal number in a team should be between six and eight midwives. Consideration was given to the participation of part-time midwives in this venture and it was decided that each team could sustain a job share without compromising the ideal of continuity of carer, thus each team should be made up of six or eight whole time equivalent midwives. Using as a baseline the individual caseloads of 38 women per midwife, the area was divided to ensure equal distribution and ascertain the number of teams required.

During this planning phase it was realised that the traditional model gave each group of midwives (community and hospital) expertise only in the specific area in which they worked. The new model under consideration would demand increased flexibility of the workforce. The midwife should accompany the woman and therefore should be capable of caring for her in all aspects required, both in hospital and community settings. This highlighted an educational and/or training need. It was addressed in the following manner. With the funds obtained for the project, ten cars fully equipped for every eventuality, complete with ten mobile phones and bleeps, were purchased. Ten

community midwives worked for three months in the unit and they were then replaced by ten unit midwives gaining experience in the community setting. Though this was very disruptive to the service, everyone felt that it was very necessary and beneficial to give all staff the opportunity to acquire the skills that would be needed in the new venture. Each midwife was interviewed and an individual learning contract was negotiated to ensure that individual learning needs were met.

Towards the end of the project year it was decided that two teams should go out as a pilot scheme to ensure that the planning would work in practice. Two of the most difficult patches were selected, with the view that if it could work well in those two, then the rest could follow with confidence. One area selected was the garrison and surrounding suburbs in the main town, close to the main unit (the 'B' MGP Team, also referred to as Team 'B', see Chapter 6) and by contrast the other was a very rural, sprawling area some considerable mileage away from the unit (the Abbey MGP, see Chapter 6). The two teams would work in isolation and therefore have no support at busy times (or sickness) as the original plan catered for. However, by exposing them to cope with the most difficult circumstances, the model could be tested in its context beyond all reasonable doubt.

The local midwives elected to denominate the teams as MGP (see Chapter 6). The first MGP to be selected was the rural one (Abbey MGP). This area had, until then, been served by three community midwives. Due to the vast geographical area of this patch and in order to render the 'on-call' system safe by achieving good response times, it was felt that one of the criteria for selection of staff for this group had to be that they lived in or close to the area. An internal advertisement was circulated stating this fact and ten midwives that fitted the criteria applied for selection. A month later the second group

was set up. This second group was to work in the area containing the garrison in the town and close to the main acute maternity unit (Team 'B'). This second group were allowed to self-select, as there were no concerns regarding distances and on-calls.

The groups were given three and two months respectively to prepare and decide how they would go about organising their work. Names were selected to identify the groups and the author was personally involved in the early meetings of the Abbey MGP (the first of the groups to be set up). This MGP decided that the 'patch' would be divided into two, with four full-time midwives in one area and three full-time midwives plus a job share in the other. There would be one midwife on-call in each area each night. Then each of the 'half patches' was divided again between each midwife, so that each individual midwife had 'her own patch' containing the approximate number of women of her caseload. It was understood that the boundaries of each individual patch had to be movable, as the pre-requisite for a sustainable caseload was no more than a maximum of forty women a year per midwife and the workload could change geographically from year to year.

The group set about selecting where each individual would work and with whom they would pair up so that they could cover the two patches over days off. This done, the first Team Leader was selected. The main market town in the patch covered by the Abbey MGP was situated sixteen miles away from the main unit and had what originally was a cottage hospital (but was now a nursing home for the elderly) where a number of satellite consultant clinics were held. The distance from the main unit was deemed to be too great for the group to practically have a base there, so with the aid of the local Hospital League of Friends, a Birthing Centre was created and furnished from the old disused kitchens of the cottage hospital (see details in Chapter 6).

This Birthing Centre had a meeting room, office, toilet for the midwives' comfort, a delivery room with en-suite bathroom including a shower, a store room and a small kitchen. This would then be used as their base where most of the group activities could be carried out. It was unmanned by midwifery staff, but the women who met the criteria had a choice to deliver there and would meet their midwife at the centre and go home a few hours after delivery. This was in line with the ethos of the 'Changing Childbirth' report (1993) that advocates that women should have a choice of various options of care. The women of the Abbey MGP could chose to deliver their baby at home, in the local Birthing Centre or in the main unit at the District General Hospital. The GPs in the area felt that they were geographically too far away from the main unit to provide intrapartum care, thus they referred all their women to the consultant obstetrician. Negotiations with the local GPs and the consultant obstetrician created the 'midwife led care' option and the women who met the low risk criteria could be seen only by a midwife whilst all parameters remained normal, or share their care between the midwife and the GP.

The Abbey Midwifery Group Practice

As stated above, one of the criteria for selection to this group was the place of residence, as the on-call cover had to be maintained and a concern was expressed at the vast mileage of the patch. Ten midwives put their names forward. It is worthy of note that the MGP started out with ten members (nine whole time equivalent) but one member left two months after commencement and thereafter the MGP re-organised and functioned with eight whole time equivalent members. Due to long-term sickness, the MGP has had members leave and subsequently been joined by other midwives on a secondment, later made permanent (see Chapters 6 and 7).

All thirteen midwives who at any time worked in the Abbey MGP had in fact participated in 'The Changing Childbirth Initiative' and had gained three months experience in the community and the main unit as appropriate. These midwives did not know each other well. Some individuals were acquainted, but not everyone in the group knew each other. This diverse group of people set out to establish agreed frameworks for the delivery of midwifery care to the women in their patch.

Many, many hours were spent reaching agreement on how best to deliver care, what could be done by the group and what had to be negotiated with the staff in the main unit because of the mileage and the time factor. A Team Leader was selected. A date was agreed and set for the two MGPs to 'go live' and all stakeholders were informed. Though the two MGPs were to be the same, they were in fact very different. The Abbey MGP was handicapped by the vast rural area it had to cover, the mileage from the main unit and the time it took to respond to calls from the main unit. The other MGP did not have any community midwives among its members; they were all part-time or full-time day/night rotational midwives working in the main unit. This is discussed in Chapters 6 and 7 of this thesis.

New uniform and working arrangements

To coincide with the creation of the MGPs, the maternity service had negotiated with the local Trust that the midwives should have an identifiably different uniform from any other staff group within the Trust. This was much more casual and practical. Each MGP member would have a fully equipped car (though the community midwives with previous lease car arrangements would be allowed to keep them), mobile phone, bleep that was automatically activated if the phone was not answered (either because of bad

reception or because the phone had been left unattended) which ensured that if the call was urgent it would be answered. Each midwife would operate in a known geographical patch and take responsibility for organising the care of thirty eight to forty women a year. No 'set' hours of work were established; the midwives would work flexible hours and work when the work was there and get their 'time back' when times were quiet (it was envisaged that the time worked would average out over a few months to their standard contracted hours, and this was backed up by the literature of the day). This issue alone was a major change in their working pattern.

Grading

It is not the author's intention within the framework of this study to discuss the political agenda surrounding the midwifery staff pay grading structure and its inappropriateness to the profession, but it was and continues to be an emotive issue for every member of staff and, as such, overshadows some of the issues for the midwives. In preparation for 'going out in the MGP', the local branches of the two unions agreed a deal with the Trust that would ensure the minimum grade for all midwives would be set at the 'F' level, with a preceptorship year at 'E' grade for the newly qualified midwives. This meant that all previously 'E' grade midwives (the majority) would benefit from a pay increase and, not least, an increased sense of 'worth', but there would also be a reduction in the numbers of 'G' grade midwives (who would have their salaries protected for a number of years).

The local Trust was one of the first to agree to the principle of a minimum 'F' grade for midwives. In order to create some degree of career opportunities, it was agreed that the MGPs would have a yearly rotational Team Leader post set at the 'G' grade, so that all members could have a chance of experiencing the 'management role' within this

framework. This meant that the MGPs would be made up of group members at 'F' grade and the leader at 'G' grade for a year. It is vital for the reader to understand the importance this issue has for each individual member of the workforce, as it will permeate all thinking and influence the relationships between staff.[10]

The rationale for this study

The MGPs went out 'live' at the end of the year in which the author held the post of project leader. She then took up a post as manager of the coastal GP units and her close involvement with the Abbey MGP came to an end. She was curious, though, to see how the various ideas that had been put forward in the many meetings with the Abbey MGP would work out for them and how they would change and evolve over time. It was this curiosity that drove her to undertake the research and gain the opportunity to follow their progress. She felt that it needed to become a longitudinal study, followed over a period of years, to allow the various adaptations and changes within the group to mature and evolve.

The author's preferred style of learning is reflective and therefore observational studies that allow for this process to take place are best suited to this learning style. The starting point would be to ask what elements of the work culture that had been established for many generations of midwives would be taken out into the 'new' way of working, if any, and what work 'culture' would evolve for the midwives in the Abbey MGP as they set out on their new 'way of working'.

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[10] Pay scales in 1988 were applied for the first time at local level, not nationally. 'G' grade represented the first level management in some units (Local Trust) (i.e. Ward Sister, band 7 in 'Agenda for Change' pay scales, since 2004). However, in other units, 'F' grade was seen as the first level of management (Ward Sister equivalent, now pay band 6 in 'Agenda for Change' pay scales, since 2004).

The study

The research took place over a six-year period and focused exclusively on the Abbey MGP, though some reference to, and comparisons with, the other MGP that was established at the same time are used from time to time, primarily to illustrate an issue that was highlighted from the data collected. This is an ethnographically inspired study of the Abbey MGP, which includes both participant and non-participant observation, including observations at ten team meetings over the five-year period. It also includes a series of taped semi-structured interviews with individual midwives of the Abbey MGP. The first set of interviews was conducted exactly six months after they had commenced this new 'way of working'. They were then re-visited at the year, two years, three years, four years, five years and six years anniversaries.

The author selected ethnography as a research approach because it fitted well with her style of learning and her interest in the use of language. Being comfortable with the method meant that all energies could then be focused on the task, and not diverted by feelings of inadequacy. Observational studies allow the author the freedom to observe and comment on just how the Abbey midwives would set out to work in what, for some, was a new environment but for all of them was a different and challenging new way of working. Chapter 5 of this study looks at culture in some depth, 'the way things are done'. Ethnography grants the author the opportunity to comment on the reality of how these midwives have embarked on the social organisation of work and developed their own unique work culture. In the next chapter, the author comments on the method selected to undertake this study.

Chapter 4

Method

The purpose of this research

This study incorporates a longitudinal period of observation of the Abbey MGP that included the collection of a series of interviews with all participating midwives at six months from the date of launch, then at yearly intervals thereafter for six years. The method chosen by the author to undertake this research has been ethnography, as it is an approach that is ideally suited to the complex task of studying health professionals at work. Having made the choice of method to be used, the author set about defining and understanding this method.

Ethnography

In attempting to define ethnography the author makes use of Conklin's definition that states:

> "the data of cultural anthropology that are derived from the direct observation of behaviour in a particular society. The making, reporting and evaluation of these observations is the task of the ethnographers" (1968, p.2).

This serves well as a basis, but on further investigation the author considered Wolcott's (1975, 1982) argument that there is confusion around the term 'ethnography', because it has become equated with the techniques of actually doing the research. He argues that the definition of this term should be constrained to the cultural perspective and not to the research technique. Burgess (1984), however, argues that many British researchers, particularly those engaged in the study of education, use the term 'ethnography' to describe the style of their work. There is also some confusion between the use of 'ethnography' and what Glaser and Strauss (1967) describe as 'grounded theory'. The

latter, however, is firmly established in the data collected and the theory is then developed from this. Field and Morse (1985) argue that, in fact, grounded theory is a form of ethnographic data analysis. Authors such as Baszanger and Dodier comment that:

> "analysis of field notes starting in the 1980s forced a revision of the traditional views of the anthropologist in the field and served as a basis for a very critical reassessment, even within the field of ethnography itself, of the authority of the ethnographer. Since that time new conceptions of ethnography have emerged. They reassert the value of field work, but focus more on demonstrating the relationship between forms of heterogeneous action rather than trying to identify a culture as a whole" (1997, p.8).

These authors go on to argue that ethnographic research is characterised by three key elements. They are:

- The need for an empirical approach, stating that "the phenomena studied cannot be deduced but requires empirical observation". This is just the case confronting the author; the phenomena of how the Abbey midwives go about their daily work, could only be studied by using empirical observation.
- The need to remain open. Baszanger and Dodier (1997) state that "the field worker must remain open in order to discover the representations of the world, the linguistic and para-linguistic resources used by people in their interactions with others and the world they operate in". In observing the Abbey midwives, the author was able to remain open to all the resources used by the midwives in their daily activities.
- A concern for grounding the phenomena observed in the field. The fieldworker needs to ensure they connect the facts observed with the backdrop against which these facts occur. Thus, the author observed the Abbey midwives against the

backdrop of setting up a new way of working within a local NHS Trust, taking into account the numerous agendas in play at the time.

Hammersley and Atkinson (1983) state that ethnography is a research method that draws on a wide range of sources of information, using multiple methods of data collection. They describe the ethnographer as:

> "the researcher that participates, overtly or covertly in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions, in fact collecting whatever data is available to throw light on the issues with which the researcher is concerned" (Hammersley and Atkinson, 1983, p.1).

In order to ensure that the author has followed this debate through and has considered a more up-to-date reference, she has turned to Smith who states that:

> "the terms ethnography, field methods, qualitative inquiry participant observation, case study, naturalistic methods, and responsive evaluation have become practically synonymous"(1992, p.458).

This comment seems to broaden the definition of ethnography and is supported by Miles and Huberman (1994), who state that in the past decade disciplines such as healthcare "have shifted to more qualitative paradigms". They argue that qualitative data, making use of words and their descriptive power rather than numbers, has become almost the 'norm' in some fields of research, notably in some areas of the social sciences.

However, according to Brewer (2000, p.5), ethnography offers an "attempt to understand society by the generation of knowledge in a rigorous and systematic manner" that gives credence to the findings. Brewer (2000) emphasises that ethnography has proved useful to policy makers, by collecting factual information from

the reality of where the policy is to be worked and implemented. This dovetails with Lipsky's (1983) work describing the 'street level bureaucrat' (referred to in Chapters 6 and 7). Brewer (2000, p.164) also comments that ethnography is particularly useful when "a longitudinal element is required in order to study social processes over time". This study is a longitudinal study of a group of midwives working in a different manner to the traditional arrangements within the NHS.

Analytically, ethnography is descriptive. The analytical task is to utilise multiple data sources (interviews, observations, diaries, etc.) and condense them in order to portray the essence of the experience studied. The ethnographer then places less importance on the conceptual or theoretical meaning in an attempt to 'tell it as it is' (Miles and Huberman, 1994). The process of analysis, however, engages the researcher's ability to reflect on the data collected, or indeed the situation in which the data was observed, and the influence her role as participant has on the data. Therefore, ethnography is more than just a static process of observation, as the element of reflection will enable the researcher to interpret the data. Hammersley and Atkinson (1983) and later Hunt and Symonds highlight the concept:

> "Ethnographers are part of the social world they study but they are able to develop the ability to stand back and reflect upon themselves and the activity of that world. This is reflectivity" (Hunt and Symonds, 1995, p.40).

The addition of the element of reflection transforms ethnography from merely describing observations to the catalyst that will enable a researcher to interpret the observational findings and shift from one perceptual perspective to another.

Ethnography in midwifery

The author considers two main authors in midwifery who have used ethnography as their chosen method. In her study 'Labouring in the dark', Kirkham states that:

> "...it's a method used to study the social world of midwifery in its natural state, as it happens and where and as it is" (1992, p.136).

Midwifery is a complex multifaceted activity. Midwives have to relate to and interact with the women they care for, the babies and their families. They also relate to each other, the management and medical hierarchy, and to colleagues working in different environments. Therefore, observation and questioning, as encompassed in ethnography, is a method that is suited to studying this complex and social world of midwifery. Hunt undertook an ethnographic study of the work of the midwife in a labour ward and, in justifying her choice of method for this study, she states that:

> "There is very little that is straightforward about the work of a midwife in a hospital labour ward. Other research methods may focus on one small aspect of care, where ethnography offers a broader approach. It aims to discover the unpredictable, the unknown, the unexpected" (Hunt, 1995, p.38).

The author concurs with Hunt that there is little that is straightforward about the work of a midwife and therefore confirmed ethnography as her method of choice.

Policy Ethnography

In studying the development and implementation of a national policy at local level, the author shifts from using only ethnography to incorporating policy ethnography into her research. This allows the author to throw light on the issues that occur when the Abbey MGP midwives determine just how to make such a policy work in the reality of their working lives. This approach will then demonstrate how this policy is worked at and shaped to fit the circumstances in which the Abbey midwives have to work. It is this

process of observing and reporting the reality of working life that will develop the 'real policy'.

> "Sometimes there are shifts in 'de facto' policy, that is, behaviour on the ground without any formal policy change" (Preister, 2003, p.7).

Authors such as Mays and Pope (1995), Pollitt *et al.* (1990) and Cox (1991) demonstrate the importance of using policy ethnography as a method that will provide a picture of the reality of the implementation of a policy, and this in turn should feed back to the policy makers.

> "Policy ethnography has a distinctive contribution to make to our understanding of the policy process" (Pollitt *et al.*, 1990, p.188).

Some features of qualitative research

The author has selected some of the features of qualitative research that she feels are worthy of mention in relation to the method of her research that will justify the rationale for her choice. Miles and Huberman (1994) urge researchers to make clear their preferences, because to know their 'conversational patter' is to understand how the data is rendered. The author enjoys the use of language and the power behind words, thus a descriptive method conforms to these criteria and allows for freedom of expression. Whilst undertaking this research, the author is aware that human relationships and interactions are influenced by the structures, conventions and practices, not only of the society in which these transpire, but also the institution in which healthcare is delivered has a powerful influence. The author herself effects an influence on the research, not least because she has to elect whether to be a participant or an observer, but also as highlighted by Atkinson:

> "What is generated as data is affected by what the ethnographer can treat as 'writable and readable'" (1992, p.9).

The element of reflection, deemed so essential above, is a very personal contribution to the research presented.

One of the main criticisms of ethnography refers to the subjectivity of this research process. It is the researcher who decides what data is to be collected, how it is collected and analysed, then finally, what data is to be included in the final written report. The alternative is a neutral, scientific and impersonal research method with an emphasis on objectivity and value-free statements. This, however, would not serve the purpose of this study which is to 'tell it as it really is'. Authors such as Garfinkel (1967), Okely (1992) and Cohen (1994) acknowledge rather than deny the position of the researcher and their influence on the research process as a valuable contribution to the process itself. It is the researcher's ability to form relationships with the participants in the study that enables the data to be elicited and generated, or conversely hinder this process (see further discussion later). The fact that the author is already known to the midwives places her in the practitioner-researcher role. This role has the advantage that the author is familiar with the environment, its existing culture and the participants, but also holds dangers of subjectivity and failure to see what is familiar.

Participant or non-participant observer

The author was confronted with making a choice as to the role she would take up as the researcher. Hammersley and Atkinson (1983) argue that throughout the fieldwork the ethnographer should remain "intellectually poised between 'familiarity' and 'strangeness'". Poundmaker (1966) and Everhart (1977) offer similar advice. Freilich (1970) advises the researcher to become a "marginal friend".

Many of the criticisms levelled at this type of research focus on the role of the researcher as participant or non-participant observer. Leininger (1969) states that it is only when the researcher becomes participant that rich data emerges. The author is aware of the dangers of 'research blindness'. There is a very real risk that the researcher may fail to become sufficiently detached from the familiar setting to be an effective researcher and the validity of the work may be compromised.

The practitioner as researcher

Professional organisations such as education and healthcare have undertaken ethnographic research by members of their own community. Polanyi (1967) highlights that an invaluable contribution to the research process is made by someone who is familiar with the study situation. Young (1991), conversely, points out that in some instances using an 'insider' may be crucial, as for example the Police Force, where a deeply ingrained distrust of social scientists prevails, leading to the development of strategies that would exclude the researcher and thus undermine the research (Stevens, 2003).

Because of the risk of inherent subjectivity, Field (1991) points out that the practitioner-researcher is viewed with scepticism. The researcher is so much part of the research process that they are unable to theoretically step back from their work and may inadvertently inflict their personal 'world view' on the research setting. The detailed knowledge they have of the wider context of the study will carry value judgements and expectations concerning practice and development of the profession. It is vital that these are acknowledged in order to avoid the reality and perception of bias (Stevens, 2003).

Authors such as Kirkham (1989), Lipson (1991) and Hunt and Symonds (1995) recognise that the best data is derived from the trusting relationships developed between the researcher and the informants, in which the researcher is acutely aware of their own influence on the relationship. The experience, skill, maturity and thoughtful insight of the researcher are vital elements in the research process. Adelman (1985) and Glesne (1999) note that it is crucial that the ethnographic researcher is accepted in the community to be studied. They also state that a good rapport is indispensable and it is essential that the researcher gives due consideration to her role.

The author was very well known to the Abbey midwives, well immersed into the culture of the organisation and familiar to the participating group, thus she was 'an insider', familiar with the jargon, the setting and the expectations of the participants. It is vital when acknowledging the strengths and potential benefits of undertaking research within her own profession that the author also identifies the possible disadvantages, thus ensuring that the potential for bias is counteracted.

The author was well aware that, having come 'through the ranks' of the organisation from her student days to manager, she would only have a very small and local view of midwifery. However, her experience of participating in a national midwifery organisation and frequently meeting and discussing issues with midwives from different areas, had caused her to reflect on her role as a midwife and her 'world view' of the midwifery profession. This was further challenged when she participated on the international scene and took part in a number of international midwifery conferences. The author also won a travelling scholarship that allowed her to spend eight weeks in Mexico working with local midwives. As she is bilingual English-Spanish, she was able

to enjoy a very enriching and rewarding experience that once more caused her to review her stance on her profession.

The 'insider'

In order to carry out the data collection, the author took on the role of observer as participant (researcher-practitioner). This role, according to Junker (1960) favours observation over participation. Again according to Junker (1960), most ethnographers take up a stance along the continuum of observer as participant and participant as observer. Authors such as Hammersley and Atkinson (1995) agree with Junker's premise.

The author's occupation, gender, age and qualifications were factors that provided acceptance as the researcher for this group of midwives. The relationships built over the years and founded on trust had been long established and were very useful in this context (the author discusses this point later). The value that this perspective brings to the research is that as a practitioner the author has the experience and knowledge of the group to be studied, thus this research may be more insightful and valuable than if it had been undertaken by an outsider to the field.

Access

After an informal verbal approach to the Head of Midwifery and the Abbey midwives, the author submitted a formal request for access to the Head of Midwifery and the Ethics Committee of the Trust (see Appendices 1 and 2). Once this formal approval was gained, the author wrote a formal request to each of the Abbey midwives explaining her rationale for the study and eliciting their support and co-operation. Once consent from all parties had been obtained, senior managers were informed and, because the local

midwifery community is so very close, it was not long before most people in the unit knew the project was underway.

> "In ethnography, access to data needs to be constantly renegotiated at all levels. In this, an understanding of the nature of the organizational hierarchy, the probable expectations of individuals at different levels, the appropriateness of timing, dress, language and behaviour facilitate access, both to individuals and then to useful data" (Stevens, 2003, p.51).

The author chose to continue in her role as a member of staff, wearing the accustomed dress and identity badge. As all members of staff were aware of the study and all Abbey midwives had been contacted individually, no distinct identifying badge was used. It was the author's desire to use her position as a midwife within the unit, in order that the study setting and interactions could be observed in as natural and undisturbed manner as possible.

However, the author was not only a midwife but also a manager, and had been involved in setting up the project to be studied. This posed potential problems, as she had to acknowledge her different roles and remain faithful to the research study. The potential for professional and research conflicts of interest were acknowledged and discussed with the Head of Midwifery and also with the author's personal Supervisor of Midwives. It was agreed that the author would undertake her role as manger and midwife first, and the research would always come second. This conflict of interests never actually materialised. The author's role as manager was primarily undertaken away from the main unit and she had very little contact with the Abbey midwives in this role. This minimised the potential for role conflict, but she was always mindful of this danger. In order to keep her mind fully focussed on this probability, the author kept a reflective diary with her personal musings of the process of data collection and other aspects of the research process. The reflective diary developed along different lines to

the field notes, as they were very personal notes recorded by the author and contained impressions, emotional outcries of frustration, many questions and personal asides that not only added colour to the field notes but also provided material that could have highlighted a conflict of interests.

Another safeguard built in was the fact that this study was undertaken as part of the requirements for a Ph.D. thesis and the author was therefore supervised by an academic outside of the organisation. This proved invaluable in identifying possible assumptions and bias, challenging ideas and assisting in the development of different ways of thinking. The use of informal networks with other midwives undertaking similar projects also provided an invaluable contribution.

Another aspect considered during data collection was that the advantage of the 'insider' stance meant that the author was familiar and could use the local jargon. She knew the Abbey midwives very well and therefore was in a position to use both verbal and non-verbal cues that would assist in allowing the data to be revealed. Knowing the Abbey midwives so well also meant that the author was aware of and understood the strategies these individuals use, and way they think and act in different situations. Another valuable asset of taking the 'insider' stance was the ability to identify hidden agendas, both within the Abbey midwives and their colleagues in the hospital or community.

The power balance

In order to carry out research, the key element required is the development of a relationship between the researcher and the participants. Authors such as Adams (1998), Luttrell (2000) and McGraw *et al.* (2000) affirm that it is the researcher who holds the power, particularly in the case of an ethnographic study. Researchers hold power as a

consequence of the choices they make (what to research, how to gather the data, who is interviewed and how the interview is to be conducted) but, most importantly, it is the researcher who analyses the data and writes the report, making the ultimate decisions as to what is to be included and how it is interpreted. The author was always acutely aware that she was in a position of power over the participants, because in her role as manager she was higher up the organisational hierarchy. Added to this was the fact that she led the implementation of the MGP. Whilst 'insider' knowledge proved invaluable in already knowing the organisational structures and planning involved in setting up the groups, the author was aware that her position could influence the way data was revealed, as people will often provide information they think is expected of them. However, the deep knowledge and understanding of the individuals assisted the author in keeping an open mind, constantly checking and assessing if comments made were in any way influenced by her position. The author was of the opinion that she was so well known by everybody that her role was secondary to her persona within the organisation.

In order to obtain quality data, the researcher needs to be accepted and trusted by the participants (Mun Wong, 1998; Sword, 1999), however:

> "in reality, the researched also hold considerable power since they can give or withhold information, access or the right to 'observe'..." (Adams, 1998, p.226).

This, in fact, was the case for this particular study. The author approached each individual Abbey midwife both informally (personally) and formally (by letter). But it was left to each individual to decide whether to participate at all, or to select just how much participation they were happy to contribute. The author refrained from pursuing such individuals for more data. Therefore, participation, the volume of the data and the choice of data itself were each participant's individual choices. Thus, the balance of power was now turned towards the participants of the research process.

Authors such as Kleinman and Copp (1993) make the point that research offers the participants a platform to express opinions that otherwise could not be expressed, or a forum to provide legitimacy to their concerns and opinions. The author was well aware that not only the individuals, but also the Abbey MGP, had an agenda when agreeing to participate in this study. She had to be mindful and conscious that this study would offer these midwives a possible platform to air their personal and collective views on a much wider programme that the one set out for this study. The author had to remain faithful to her remit of telling the Abbey midwives' story through her research.

> "Writing is the essence of research, but usually given little attention, research reports are about telling a story. The emphasis on reflective practice emphasises the self as story teller" (Usher, 1997, p.222).

In order to remain faithful to the principals of good research, the author took heed of the advice offered by Elliot:

> "In order to be effective the insider researcher should consider dismantling the value structure of privacy, territory and hierarchy and substituting the values of openness, shared critical responsibility and rational autonomy" (1991, p.67).

The author made every possible attempt to use these values.

The emotional cost

In her role of the 'insider', the author had to maintain neutrality. She had to display a neutral stance and demeanour in all her contacts with the Abbey midwives. She could not share her true feelings with members of the group or with management. She could not use confidential information from individuals, the group or from management. As an observer, she could not influence the data and all this came at a personal cost.

The hiding or changing of true feelings in an attempt to portray an acceptable emotional stance has been identified by Hochschild (1983) as emotional labour. She was the first to identify emotional labour as a form of work, describing it as "the management of feelings to create a publicly observable facial and bodily display" (Hochschild, 1983, p.7). Ashford and Humphrey (1993, p.90) later adapted a definition of emotional labour in the service roles, calling it "the act of displaying the appropriate emotion".

As an 'insider', the author had to act in a certain way in order to become so familiar to the Abbey midwives that they almost 'forgot' that she was present observing them. At interview the author adopted a courteous, pleasant and open demeanour in order to facilitate the flow of data and gain acceptance. The author, however, was acutely aware that in her management role she also had a 'foot in both camps' and, though she was unable to remove all power imbalances and contradictions as advocated by Luttrell (2000), she was able to acknowledge them in her diaries and also, as stated by Jarzabkowski (2001), she was able to acknowledge 'her self' as the ethnographer. One of the emotional costs associated with this study was that the author experienced stress in attempting to remain neutral and live for such a prolonged period of time with 'a foot in both camps'. However, she gained a deeper understanding of the emotional dimensions of collegial relationships and remembered Luttrell's (2000, p.517) advice that "at its core, ethnographic research is creative, inventive, emotionally charged and uneasy".

Reciprocity

The author was well aware that the Abbey midwives could and would use the opportunity of her attention to see her as a source of 'insider' knowledge, and would seek information particularly on management's future strategy and the fast moving

political and financial agendas. Data analysis, however, does not reflect this and the author's concerns were in fact unfounded. However, it is worthy of note that the author was pleasantly surprised by the eagerness, openness and frank speaking that took place during the interviews in varying degrees. She concluded that, as demonstrated by Stevens (2003), making herself available to actively listen to an individual midwife's views, providing a 'safe' environment in which to express the feelings and emotions experienced, demonstrated respect for them personally. This was particularly so when the author asked these midwives to describe the impact working in this way had on them personally. The opportunity to speak about the impact of work on personal life is not frequently experienced by midwifery staff. Stevens (2003) also highlights the fact that participating in interviews allows midwives to reflect on their practice. The author found that the interviews scheduled at one year intervals provided the Abbey midwives with this opportunity and the verbal feedback was very positive. This provided an element of reciprocity into this research process.

Ethical Issues

When approaching a study of this nature there are a number of ethical issues to be considered, such as value, access and consent.

Value

The fundamental premise of any research is that it should contribute to new knowledge and, in this particular case, that it should contribute to the midwifery knowledge base. The arrival of the 'Changing Childbirth' report (DoH, 1993) sparked the setting up of various types of midwifery teams in order to attempt to provide continuity of care. As demonstrated in Chapter 2, the main focus in the literature was based firmly on the experiences of the women using the service and the organisational changes that had

been developed. There was nothing at the time of commencing this research study that focused solely on the experiences of the midwives involved. Therefore, this study set out to redress a gap in the knowledge and aims to tell the story of the development of the Abbey MGP midwives. The local Trust considered this a valuable contribution and was forthcoming with their support.

Access

The author sought the approval of the Trust's Research Ethics Committee (see Appendix 2) and consent was subsequently given to approach the Abbey midwives. The midwives were consequently formally approached and advised that their participation was voluntary, they could withdraw at any time during the study, the level of participation was their personal choice and that the author would not pursue any member who felt they could not contribute to any aspect of data collecting. The author also advertised her project to all midwives working in the Trust in order to avoid any concerns on 'working behind people's backs' (see Appendix 3).

Consent

The essence of all research is that all participants give their informed consent before participating in the study. Homan (1991) states that all aspects of the study should be disclosed. However, at the beginning of this longitudinal study the author had in reality little idea of the various alleyways the data would take her down, therefore she sought a general consent that she anticipated would cover all eventualities. There were times in the study when Abbey midwives would provide data that the author considered of a confidential nature which, if revealed, could have the potential of disrupting the group. She was able to discuss this dilemma with her academic supervisor and opted to obtain

further specific consent from the midwife involved, being mindful that if this data was to be used, she would refer to it in general terms only.

This issue confronted the author with addressing confidentiality. Ethical research relies on confidentiality through anonymity. The problem encountered in this study was that the Abbey midwives were a small identifiable group, and the author was mindful that the risk of having their views identified or made public knowledge could hinder the provision of honest and openly expressed views. In this instance, there is also the risk that individuals, though not named, may be recognised by other members of staff. However, in her favour, the author had embarked on a longitudinal study and the movement of individuals within the NHS assisted in achieving a degree of anonymity. Stevens (2003, p.60) identifies that total anonymity cannot be guaranteed but "the desire for anonymity does presuppose compromising or negative reporting".

Stevens (2003) quotes the work of Lathlean (1996), which describes how the adherence to maintaining confidentiality resulted in a report that was heavily criticised for lacking the essence of the situation being described. In an attempt to remain faithful to the research process yet respect anonymity, the author discussed these issues with the Abbey midwives and made it clear that while every attempt would be made to ensure anonymity, it was inevitable that individuals from such a small group might be identified by other members of the local maternity service. As highlighted by Fraser:

> "...of more importance than assuring anonymity, is to be honest at the outset about the degree to which anonymity and confidentiality can be guaranteed" (1997, p.167).

The general consensus of the Abbey midwives was that the importance of the knowledge gained would outweigh the risk of potential harm to these midwives, and they supported the author's decision to continue with this study.

Data collection

When undertaking an ethnographic study in the maternity service, there is the potential to involve a great number of people. Thus, for practical purposes, this study focuses primarily on the Abbey midwives themselves. However, it is acknowledged that hospital, community midwives and the second MGP midwives would also contribute to the study by offering a point of comparison.

The management structure of the local maternity service comprises of a Head of Midwifery, under whom are two senior midwives; one manages the main unit and the two group practices, while the other manages the two coastal units and has a dual role as the Professional Development Midwife responsible for in-service education. The latter is the author's post. In order to share the workload, the author undertook to manage the entire service one day a week, so that her colleague could have time to devote herself to administration. She also covered her colleague during leave or sick leave, and it was in this role as manager that the author came into contact with the midwives of the Abbey MGP from time to time and used this as a source of observation. She was able to observe them at work in the main unit, their interaction with each other, with midwives from the other MGP, and with the midwives and doctors in the unit. One of the consultant obstetricians cared for the women within the Abbey MGP patch, undertaking a satellite antenatal clinic at the local cottage hospital.[11] They were referred to him by the local GPs because they did not provide intrapartum care. The author was able to observe the Abbey midwives interact with this consultant from time to time, and these observations contributed to the data.

[11] This service has now been withdrawn and the women have to travel up to the main unit to see the consultant.

The author was able to attend ten team meetings throughout this period of time, and again she used these opportunities for observation and discussion in the 'focus group' format. The author did not go out with an individual midwife in her car nor follow her daily work to observe her interaction with the women, as she felt that this would be far too intrusive for both the women and the midwife. The researcher thus restricted her observations to their interactions with their women (and other women, not of their caseload, there at the time) in the unit. In order to add the women's perspectives to this research, the author accessed randomly selected feedback letters from some of the women cared for by the Abbey MGP (see Appendix 5).

The author also conducted 'exit' interviews with the two midwives who left the MGP to return to the main unit. During this time of data collection, the Abbey MGP were nominated, by a grateful woman cared for by them, for the Charter Mark for Excellent Service. The author was able to access some of the information prepared for this venture and has included it in this research (when referring to 'women', the author means both women as mothers-to-be and newly delivered mothers). Informal and serendipitous meetings and chats with Abbey midwives, unit/community midwives and student midwives who had spent time out with the Abbey midwives also elicited useful data.

The data for this research was obtained using a variety of methods. The author felt that observation required more substance and, in order to try and eliminate bias, she elected to complement her observations by interviews. Miles and Huberman state that:

> "if you self-consciously set out to collect and double check findings, using multiple sources and modes of evidence, the verification process will largely be built into data collection as you go" (1994, p.267).

Direct observations were recorded by the author as soon as possible. This meant ensuring that her diary, set up for this purpose, and her Dictaphone were always available. The author attended team meetings by invitation from the group, but also obtained their consent to 'drop in' unannounced. This research project did not hinder the author's participation in the meetings and encouraged the 'friendly native' stance taken by the author. These occasions created the opportunities for discussion among the members of the group present of subjects or ideas that the author felt needed clarifying or expanding.

McGuire (1998) expresses the opinion that a group made up of familiar individuals is more likely to lead to a more interactive discussion. However, there are problems with this method of data collection, primarily conformity and compliance. The role of the facilitator, in this case the researcher, is vital in picking up these trends. A good understanding of group dynamics is essential when using this method (McGuire, 1998). The researcher also needs to bear in mind that:

> "we typically approach the groups we study trailing an impedimenta of theoretical and conceptual ideas. In doing so we often forget that research participants have their own theories about what they do and why they do it" (Lee, 1996, p.1).

The author had to return to this advice at frequent intervals, in order to ensure that bias was minimised. Each member of the group was interviewed personally and away from the work environment after six months and then at yearly intervals. The members who left the group agreed to an 'exit' interview and the new members who took their place were interviewed as per original schedule. The interviews were semi-structured in nature and tape recorded. At the beginning of each session, the individual was informed that the interview would be taped and confidentiality was highlighted. The author then indicated the approximate time set out for this and the agenda to be covered. Each

individual was reminded that it was not essential to cover all the topics and there was no need to adhere to any specific order. The author also reminded the individual member that they were free to seek clarification at any stage, and also free to refrain from answering a question or making a comment.

The interviews were of a conversational style and both the author and interviewee were able to interact freely during this time. In fact, it was often noted by the interviewee that they were only reminded that the tape recorder was on when the tape finished and the apparatus came to a stop; the tape was then turned over and the interview recommenced with little hindrance in the flow of conversation. Silverman has highlighted that:

> "...field work routinely involves immersion in a culture over a period of years, based on learning the language and participating in social events with them" (1993, p.31).

An advantage the author has is that, as a 'friendly native', she knows the 'language' of this particular group. This proved to be very helpful in maintaining good communication and an asset when attempting to understand body language and covert meanings within the group or between individuals of the group.

One of the problems confronting any researcher is to decide if she/he will believe at face value what is said to them in the course of data collection. Glasser and Loughlin (1987) state that it is important for the researcher to establish a 'rapport', because this will allow interviewers to be "accepted as peer group members" and thus be able to show "genuine interest in understanding the interviewee's experiences".

The author not only kept 'field notes', but also maintained a reflective diary with her personal thoughts and ideas. This follows the advice given by Burgess (1984), when he defines substantive field notes as "a continuous record of the situations, events and

conversations in which the researcher participates" (1984, p.167). He also defines personal reflections as "methodological notes". The author found these notes to be beneficial, because it allowed her the freedom to express every thought related to the project; however challenging or even unrelated at the time - they somehow linked or sparked further reflection that generated more data. She also used this forum to express her personal feelings about the project, the private notes and comments on personalities and some of the difficulties with time management. The author returned to the substantive field notes from time to time to add marginal comments that were recalled later in the day. All notes, diaries and tapes were kept secure by the author, strictly unavailable to any other person. As time passed, the author was able to focus more on the content of her field notes and not so much of the background detail was included (only if relevant to the moment).

The tape recordings were transcribed and the data from the field notes and reflective writings were added, in order that all the data available was made ready for the analytical process.

Data collection methods

Table A4, contained in Appendix 4, summarises the variety of data collection methods used in this study. This allows for the process of triangulation of the perspective to be elicited and minimises the possible distortion by personal agendas or specific events. The table illustrates how every opportunity offered was used for observation by conducting the semi-structured interviews at regular predetermined intervals and attending meetings as a 'participant observer'.

Hammersley and Atkinson (1995) suggest that the ethnographer should take every opening offered to ask questions and listen to what is going on. Thus, the author availed herself of every serendipitous chance that presented itself whilst participating in the daily life of a busy maternity service.

Reflective writing

During the last year of data collection (2002), the author asked the Abbey midwives to submit a piece of reflective writing (length and depth left to individual choice) that summed up for them their feelings about working in the Abbey MGP. Once again, anonymity was discussed and assured. This was entirely voluntary and left to each individual midwife to submit. The author did not pursue members of the group who did not contribute in this way. She felt that this would give these midwives the opportunity to express themselves freely without the formality of an interview. Three midwives submitted written work. A lot of what they had to say was, in fact, the same (see Appendix 6 for a summary of the reflective writing submitted).

Time

One of the major obstacles to the smooth running of the process of data collection for this research was the time factor. In the hectic and pressurised healthcare environment at that time, the author found it difficult at times to 'ring fence' time for this purpose. She had to resort to being ruthless in placing the allocated time in her diary and ensuring that she adhered to it. The 'flexible' way of working also conspired against this, as often the midwife and the author would agree a date and time only to find that, for the midwife, one of 'her ladies' was in labour and the appointment had to be rescheduled. The author was able to achieve the task by imposing this very strict discipline on her time, but it often added pressures to an overcrowded diary of commitments. At times, the author did

feel that perhaps this was too big a task to achieve in the time allocated, but experience has taught her that time is a very subjective element and perseverance pays off.

Data Analysis

On completion of the data collection process, the author was engulfed in an overwhelming feeling of intellectual chaos. The author experienced the recurring nightmares faced by most qualitative researchers:

> "In the first nightmare, the data is no good. They have not illuminated what they are supposed to. In the second nightmare systematic error has occurred (commonly in the form of biased responses) in the most important data. In the third nightmare, conclusions come out of the wringer of successively more sophisticated analyses looking trivial or trite. And the fourth nightmare, the data resist analysis, are opaque, even inscrutable" (Miles and Huberman, 1994, p.77).

The author found consolation in remembering that this was and is a shared experience faced by all qualitative researchers, particularly when attempting to undertake that process alone. The value of a support network comes into its own during this time.

The primary aim of this data analysis is to produce an accurate representation and develop an understanding of what working as an Abbey midwife is in reality, within the local maternity service. During the early stages of the analytical process, most of the data looked promising and the author felt that 'everything mattered', but the volume of data originated required selection. The author argues that this process of selection is woven into the analytical process. At this stage, consideration was given to eliciting assistance by using a qualitative data analysis computer software package. This, however, was discarded after reading about their mechanistic approach to data analysis. The author felt that the effort involved in personally collecting the data would be rewarded by painstakingly undertaking a 'manual' analysis of the data, however labour

intensive. The author was mindful of Kvale's (1988, p.97) advice to "beware of transcripts, as they are transformations of one mode of a conversation, into another mode: narrative discourse". This forms part of the ongoing selection process that occurs in data collection. The author inevitably transcribed the conversation, but missed out the non-verbal communication unless highlighted at the time to serve a purpose.

The first data to be analysed were the transcripts of the Abbey midwives' interviews. These transcripts were read in detail a number of times and a list of possible categories emerged. These were then grouped together and organised into potential themes. The remaining transcripts of meetings, field notes and reflective diary notes were read in detail and allocated to a previously defined theme.

The data were coded according to the author's personal view of the material. Further detailed analysis generated sub-categories. The data were also coded according to the timeframe used; this enabled the retention of the longitudinal perspective. The author took heed of the advice offered by Miles and Huberman (1994) and developed a visual display of the analytical process. As the process developed, so the display would evolve and change. No specific model was used, as the author felt that freedom of expression was essential. Thus, she developed her own eclectic model. A large whiteboard was used for this purpose and this facilitated rapid changes to the display.

Carney (1990) defines this process as a 'ladder of abstraction' and the validity of the visual display for the author was that it assisted her in keeping the analysis focused. The data used in the display by necessity was condensed and this in itself formed part of the analytical process. The author is aware of the advice offered by Miles and Huberman (1994), that it is an advantage to include a copy of the display in the final document as

"the reader can recreate your intellectual journey with confidence". This, however, has not been a practical consideration due to the evolving nature of the display. The author has aimed to describe whenever possible the analytical process, in order that the reader may assess the validity of this account.

The author discovered that writing generates analysis, as the mental process involves analysis and rumination on the meaning of the words. Lofland and Lofland describe the process thus:

> "it seems, in fact, that you do not truly begin to think until you attempt to lay out your ideas and information into successive sentences... For better or for worse, when you actually start writing you begin to get new ideas, to see new connections, to remember material you had forgotten... You are never truly inside a topic - or on top of it - until you face the hard task of explaining it to someone else... (thus 'writing blocks' are perhaps better thought of as 'thinking blocks')" (1984, pp.142-143).

Miles and Huberman (1994) state that "writing, in fact does not come after analysis, it is analysis". This is the author's experience and she has discovered that, in fact, it is in the writing that the analytical process is at its most productive.

Validity and reliability

These two concepts are considered by authors such as Hammersley (1992), Guba and Lincoln (1989) and Brewer (2000) to hold very little relevance to ethnography, as their use in evaluating studies focused on social worlds, with multiple layers of meaning, proves very difficult. Nevertheless, the issue of the quality of the study needs to be considered and the author suggests that the six years of this longitudinal study allowed for an extended period of observation that mitigated against particular participant bias (putting 'up a front' for the researcher, or pursuing personal agendas). She also

considers that an inclusive approach was used. This means that all Abbey midwives were invited to participate, including new members joining during the period of observation of the group. This open invitation to participate was a key feature of this study. As commented earlier, the amount and level of participation was left to each individual midwife.

Another important factor to consider is the amount of data. It is essential to consider whether enough data has been collected to achieve depth to the scope of the investigation. It is also imperative to ensure the identification of the most relevant characteristics of the situation under investigation. This was achieved by seeking 'saturation' in the data collection and analysis. This means that the author undertook the analysis only when no further new or unexpected points emerged in the data. This was also addressed by using 'triangulation', that is to consider each observable fact and experience from a variety of angles such as:

1. using a variety of data collection methods to annul the potential biases inherent in each of them. This was achieved using observation and interviews;
2. undertaking each data collection at different times and in different places to counteract time and place bias; and
3. undertaking data collection from different participants to the main group to widen the scope, depth and variety of the data.

Constant feedback allowed for the development of ideas and testing the possible developing themes to produce 'responsive focusing', as advocated by Guba and Lincoln (1989).

The use of peer debriefing proved invaluable in assisting the author to remain focused and contributed to the challenging of ideas that form an integral part of the process of analysis. This was achieved by accessing the support network of colleagues undertaking similar studies, but outside of the organisation.

It is argued that in ethnography, the group and setting studied share essential characteristics with other groups functioning in similar circumstances. The author has sought to write in a descriptive narrative style, in order to enable the reader to see similarities with the work they themselves have knowledge of and that it 'rings true' with their personal experiences. Thus, as emphasised by Guba and Lincoln (1989), it is the reader who takes on the responsibility of judging the value of this study.

Finally, this thesis has been carefully read by a member of the Abbey MGP and her comments are positive, as she remarks that this experience was "*like staring in a mirror at ourselves*", thus reassuring the author that her work was in fact telling 'their' story.

In the next chapter, the author will consider the influence that culture has on society and the different cultures that apply to this group of midwives in their working environment.

Chapter 5

Culture

Definition

Mullins (1999) tells us that 'culture' is a notoriously difficult concept to define. Robbins (1996, p.29) believes that "most people are unaware of just how much culture will affect them". In the same vein, Etzioni (1964, p.31) makes the declaration that "culture is like fish to water. It is there all the time but the fish are oblivious to it". Therefore, we can deduce that this is a concept that most are aware of but find difficult to define. Put simply, culture can be defined as "how things are done round here" (Mullins, 1999, p.803). This simple definition provides the essence of the concept that is applied to every aspect of life: work, social and spiritual. Every individual is influenced by different cultures surrounding them as they function in each of their aspects of life. For the purpose of this study, the author will focus on the work culture, because it is this aspect that first sparked her curiosity which generated this research.

The Abbey midwives had been working within the culture of an ordinary NHS hospital. They had absorbed and worked within the parameters of this work culture. Kirkham comments that the NHS re-organisation of 1974,

> "moved the organisation of relatively autonomous community midwives into the hierarchical structures of hospitals where midwives' practice was already visible and tightly controlled" (1999, p.733).

The author set out to investigate the subject of 'NHS working culture' as experienced by midwives, and has discovered that this theme does not stand alone, but seems to be woven into organisational, professional and managerial cultures.

Professional culture

The history of midwifery can be traced back to (probably) the second millennium BC, as the earliest reference is found in the book of Genesis in The Bible. It is also worthy to note that "until the seventeenth century no word existed in any tongue to signify a *male* birth attendant" (Donnison, 1988, p.11).

Donnison (1988) traces the history of midwifery through the ages and charts the various vicissitudes of the evolving profession. It is in 1720, with the introduction of midwifery forceps, that midwifery as a unique profession of women for women starts to come under the sway and authority of the medical men able to use their 'instruments' to save lives. Donnison highlights the gradual demise of professional independence from this point in the profession's history and the subsequent medical domination of midwifery. In 1902, the first Midwife's Act was passed by Parliament and midwifery attempted once more to safeguard some professional credibility, though by now heavily under medical domination. Midwives were also less able to negotiate effectively than their nursing colleagues because, as a professional organisation, the numbers represented were far fewer than nursing and therefore midwifery was grouped with nursing and health visiting under 'nursing organisations' (Donnison, 1988; Tew, 1990).

Thus, the midwife working in the NHS hospital environment works within the medical model parameters of maternity care and is regarded as a 'nurse' that cares for babies or, at best, a 'specialism' of nursing, by the vast majority of hospital personnel. Hunt and Symonds (1995) identify the move of midwifery into hospital as the loss of professional independence for midwifery because, in the hospital environment, nursing was the dominant profession after medics.

This reality is, however, in conflict with midwifery's basic and fundamental criterion that 'a midwife is an independent practitioner in her own right'. It is this statement that allows each midwife to retain a distinct identity from nursing. Ideologically, midwifery is about health, the management of normal labour, and having a partnership with doctors and independent practitioners, whilst nursing may be seen as being dependent or a 'handmaiden', often subservient to doctors. Nursing is primarily about providing for the sick and, therefore, dealing with illness. It is, however, frequently little more than an ideal, as within the hospital culture the supremacy of doctors (who use both power and authority) places the midwife in the subservient role (Hunt and Symonds, 1995).

Midwifery has long struggled to maintain at least an element of professional independence, but faced with overwhelming power and authority from the medical profession has attempted to safeguard the process of 'normal birth'. Sadly, even this process is now having its parameters changed by technologies and intrusive techniques medically generated (Williams, 1998; Downe, 2001; Dr Foster, 2001).

> "There is little cultural experience of anything other than technological birthing for the current generation of women having babies in Western cultures" (Downe, 2001, p.1).

This leaves the midwife having to accept the technology culture that is prevalent in hospitals, in order to not only retain a job but also retain a place within the maternity service. Thus, working in a subculture, that is defined as:

> "...part of an organization's culture that differs slightly from the widely held beliefs, behaviours and assumptions of the organization" (http://www.producticity.com/glossary).

Midwives are experiencing apathy, low morale and disillusion, leading to the current crisis in recruitment and retention. Kirkham, in her study of the culture of midwifery in the NHS in England, states that:

> "the culture of midwifery which emerges from this study is one where the traditional midwifery activities of support and care continue but within organisations with very different values" (1999, p.737).

Authors such as Exworthy and Halford (1999) describe the dilemma faced by professionals working within the NHS organisation. The dissonance between their professional role and managerial hierarchy demands compromise, often at the expense of professional independence. Hunter (2002) was able to demonstrate that within midwifery, two differing models and ideologies can be identified with contradictory values and perspectives. She describes them as the 'with woman' and 'with institution' models.

Sociologists, such as Haralambos (1987), describe the process in which new members of a profession learn and absorb the culture as a process of socialisation. Blane (1986) informs us that senior members of a profession perpetuate their culture by moulding the next generation in their image, thus making professions stable and conservative. Hadikin and O'Driscoll (2000) suggest that it takes approximately 30 years for traditions and customs to become absorbed into professional culture. This is due to the generation overlap. This explains why it is so very difficult to change professional culture - even exerting some influence can seem impossible. Unfortunately for midwifery, the move to professional recognition has come at the price of independence. The evidence is that when midwives wish to practice with total professional independence, they can only do so outside of the NHS, in private practice.

Organisational culture

Mullins (1999) suggests that though most people understand what is meant by 'organisational culture', it is nonetheless a general concept that is difficult to define or

explain. At its most basic, organisational culture is 'the way things are done here'. Handy (1993) subdivides organisational culture into four main types: power, role, task and person cultures. He also states that large organisations are likely to have a mixture of some or all of the types of culture he describes. The author would suggest that the hospital midwives function within an organisational culture that Handy (1993) describes as a bureaucracy and task culture, where influence is based on expert power. This is expressed by Tew:

> "As obstetricians became more confident to use the interventions at their disposal, they increasingly abandoned the philosophy of restraint. They redefined normality in pregnancy and labour to justify the widespread use of interventions" (1990, p.9).

The hospital midwife is then attempting to function in an organisational culture that is in direct conflict to those ideals of her profession that encourage her to feel that she is an independent practitioner in her own right, and that her role and essence is to be 'with woman'. The reality of most labour wards is that midwives have in fact been weaned from these ideals into accepting technology and intervention as normal, and now function as obstetric nurses. Tew (1990) argues that midwives working in this culture have found practical compensations for the loss of job satisfaction associated with continuity of care, and have embraced the attraction of predictable hours of work and regular shift patterns.

In total contrast, the Abbey midwives have been granted the opportunity of working away, both physically and ideologically, from the hospital and have been able to function as 'real midwives'. They thus experience independence and job satisfaction. They have given up the predictable shifts, but embrace continuity of care, where the rewards far outweigh the inconvenience. Even when the Abbey midwives are working in the hospital, they seem to retain this independence.

The Abbey midwives are often observed to remain with their women in the room, they do not spend so much of the time socialising with their colleagues. It is often the comment from the 'G' grade in charge of labour ward that she never knows what is going on in the rooms occupied by Abbey ladies with their midwives, because 'they never come out of there'. The other comment often picked up is 'she has been there for hours'. There is a great voiced emphasis on the word 'hours'. I believe there is jealousy of the Abbey midwives' ability to practise as real midwives, this is not often expressed and the emphasis on the word 'hours' indicates to me that they secretly wish the Abbey midwife home. I believe this jealousy, not acknowledged nor expressed, to be at the root of the 'them' and 'us' divide that has evolved.

(from field notes)

The model set by this example of MGP offers the midwifery profession the possibility of embracing once more its true ideals to be 'with woman'.

Managerial culture

In the present climate of a quasi-market ideology in the NHS, managers are urged to develop strategies for controlling the organisation's output in order to meet the contracts entered into. This has generated a change in the management structures of Trusts.

They now have internal organisations built around 'clinical directorates', headed by consultants working closely with a senior manager, and in the case of the local Trust, the Clinical Director is an obstetrician and the Directorate Manager, the Head of Midwifery. This strategy is seen as an attempt to involve medics in managing other doctors and developing an awareness of budgetary controls/constraints, thus making it easier for managers to challenge medics over their use of resources and the service they wish to develop (Harrison and Pollitt, 1994; Exworthy and Halford, 1999). According to Exworthy and Halford, "doctors themselves have initiated the practice of 'medical audit', implementing the language of accountancy in the transformation of the NHS" (1999, p.108). This denotes, for the author, the power struggle that continues between

medics and managers. As exemplified by Exworthy and Halford (1999), the attempts to get both these groups (professionals and managers) to work together, with one mind, still has a long way to go.

Kirkham (1999) describes, in her study of midwifery culture in the NHS, the view expressed by many midwives of a need for support that goes unacknowledged, in favour of loyalty to the organisation midwives serve. Midwives find it difficult to seek support when they see that the culture developed perceives it as a failure. Both their managers and supervisors are just as stressed and overworked as they are, and loyalty to their organisational culture hinders their ability to acknowledge their own needs. Kirkham (1999) also highlights the finding that "midwives found the concept of an oppressed group relevant to midwifery", but more telling is that these midwives identified the "source of the oppression as emanating from the general NHS management" ethos. Thus, midwives today are working in a culture of contradictions. The move into hospitals provided the shift structure, better working hours, professional support from medical colleagues (obstetricians, paediatricians, anaesthetists) all at hand in the event of an emergency, but managed in a system that is focused on targets and performance.

The Abbey midwives, as discussed in Chapters 2, 6, 7 and 8, are physically located away from the main unit and based in the community they serve. This repositioning has allowed them the opportunity to redress the balance between loyalty to the woman and the organisation. These midwives have a degree of freedom and control over their work that allows them the 'luxury' of having the opportunity to establish a trusting relationship with the women. It also provides them with both immense job satisfaction and protection against work-related stress or burnout, as argued by Sandall (1995).

Bureaucracy

According to Mullins (1999), bureaucracy is a structure that is characteristic of most large organisations such as the NHS. Weber states that:

> "the decisive reason for the advance of bureaucratic organizations has always been its technical superiority over any other form of organization" (1964, p.324).

The main characteristics of bureaucracies are:

> - "an implied clear-cut division of labour and a high level of specialism;
> - a hierarchical authority exists;
> - uniformity of decisions achieved through formally established systems of rules and regulations.
>
> [It also incorporates:]
>
> - an impersonal approach to both clients and staff to ensure rational judgements are not contaminated by the personal touch or consideration.
> - Employment in the organization is based on technical qualifications and performance with a guaranteed lifelong career" (Weber, 1964, p. 324).

There is no question that these characteristics are clearly reflected in the values of the NHS and, to some extent, shape the environment in which midwives function.

One aspect that is worthy of note is the hierarchical nature of the organisation and the gender orientation of such. Some organisations are deemed to be male-dominated. They were originally derived from the army, church and government. Although midwifery is predominately a female organisation, it works primarily within the NHS, which in turn employs a vast number of women (although they do not, in the main, occupy the positions of power, nor are they responsible for designing the organisation's management structure) (Freidson, 1970; Kirkham, 1999; Hadikin and O'Driscoll, 2000). In midwifery, although the Head of Midwifery may be female, she has no place at Trust Board level, and the obstetricians have more power and influence at this level than

midwives. Even if some of the consultant obstetricians are female, it is the culture they are educated in that perpetuates the male thinking and power base. According to Mullins, "the hidden curriculum supports the notion of male dominance" (1999, p.333). Davis (1995) affirms that the cultural codes of gender influence not only the individual, but also the structures of social institutions. According to Candib, "for centuries, traditional medicine has been infused with masculine bias" (1995, p.3).

The Feminist Research Centre (www.feminist.org/research/medicine/ewm-toc.hyml), states that at the current rates of medical school professors, women will not reach parity on medical school faculties until the year 2077. They also highlight that not a single medical school in that country (USA) is headed by a woman dean. This practical example can be seen as confirming the stance, of the authors named above, that a masculine gender bias continues to exist in our healthcare institutions.

The work culture developed by the Abbey midwives

When setting out to find out just how the Abbey midwives would adapt to the new way of working, the author was influenced by the work of Kirkham (1992) and Hunt (1995), both of whom used ethnography as an approach which proved highly appropriate for undertaking a study of midwifery culture.

As described in some considerable detail in Chapter 4 of this study, ethnography is the method of choice to describe the culture developed by the Abbey midwives. Their working patterns may be very different from the hospital structures they were familiar with, and the author was curious to understand how they would adapt to the new way of working. The outcome would also demonstrate just how a national policy to give

women more continuity and choice in the maternity service (DoH, 1993) would be implemented by the very people that provide the service.

This study describes in great detail the culture that the Abbey midwives developed over the years. It is to be understood that this is a development progressing along a continuum, as the group adjusts to new members and finds new ways of 'doing things'.

It has been stressed that at the very core of the Abbey MGP culture lies the provision of continuity of carer and the abolition of set shifts. The Abbey midwives are adamant that in giving up the convenience of shift hours they have in fact gained self esteem, confidence, job satisfaction and joy in their work. Through the use of ethnography, the author has described how they are able to exert some control over their work, often manipulating the caseload allocation to ensure continuity not only in this pregnancy but from one pregnancy to another. The relationship between these midwives and the women is very strong, and an alliance has developed between midwives and women which allows them to manipulate the system together. These activities are exactly those which other research approaches might well have missed, proving once again the appropriateness of the choice of ethnography if one is to understand the detail of policy implementation in practice.

The Abbey midwives have seen their confidence as practitioners increase and they now dare to pay lip service to the organisational culture of the hospital because they are metaphorically and professionally far removed from it. As described above, this stepping away from the organisation allows the Abbey midwives to practise as independent practitioners, as they are making most of the professional decisions on their

own. This has generated a sense of jealousy from their colleagues that enhances the 'them' and 'us' situation which has arisen.

The Abbey midwives have as the pivotal anchor of their work culture the relationship with the women they care for. This relationship is key to all aspects of their development, both professional and personal. As a consequence of this relationship which is, as highlighted in this study, founded on trust, the Abbey midwives listen to their women and gain new ideas from them. This, then, leads to research and continued education and a commitment to life-long learning. The reward for all this commitment to time, emotional vulnerability, learning and work is the high level of job satisfaction obtained.

The results of this study indicate that the author believes that the Abbey midwives have developed a working culture that returns to the ethos of the midwifery profession, which espouses two principles: to be 'with woman' and to employ both the science and the art of midwifery. The author argues that this study demonstrates that within the organisational framework of the hospital, the art of midwifery is lost. The Abbey midwives have been granted the opportunity and confidence to reclaim the art of midwifery to the benefit of the women they serve, as well as to their personal and professional development. These findings support the work undertaken by Hunter (2002) that revealed similar conclusions.

The Abbey midwives do not work in a vacuum, however tenuously, they belong to the organisation of the NHS. This study demonstrates just how successful and satisfying this model is for both the women and the midwives. It has seen the charting of the transformation of the Abbey midwives from hospital/community to Group Practice

midwives. They have developed a unique culture that allows for professional development and job satisfaction. In the next section of this thesis, the author presents the three analytical themes that have emerged from the data collected. The following chapter analyses the early stages of the development of these midwives into a team that embraced new working practices.

Chapter 6

Early days in 'The Team'

Prologue

For the purposes of this thesis, the author has highlighted in italics the words spoken by a member of the Abbey MGP, but has not identified the individual. The words uttered by other speakers have been identified in the narrative. Data originated as direct observation by the author has been identified and, where she deems it appropriate, other relevant information accompanies these data. In order to achieve a narrative that flows in logical sequence, the author has occasionally highlighted the timescale into which the data fits. The reader should, in most instances, take it for granted that the narrative is sequential in timescale from the beginning of the paragraph.

The data analysis (described in Chapter 4) revealed three main themes. These three themes have not been arranged in any specific order and will be discussed in the following chapters. This chapter, and the one which follows it, refer to the theme that has been called 'The Team'. This theme allows us to explore the way in which the team developed over time, some of the practical arrangements put in place to support the team and how the midwives reacted to these. It also allows the author to explore Tuckman's (1965) concept of team development against a real example.

Comparisons

This study does not set out to investigate the comparisons between the Abbey MGP and Team 'B,' the other pilot MGP (this study being an ethnographic case study of the Abbey MGP), but it is inevitable that an element of comparison is made in order to explain or highlight an issue. The original pilot project consisted of sending out two teams (as described in Chapter 3). When necessary, the points of comparison will be clearly marked in the text.

Introduction

Authors such as Tuckman (1965) and Blair (2000) have written extensively on the team development process (as described in Chapter 2). Tuckman (1965) describes four basic stages of the process and, in the following narrative that describes the Abbey MGP's development as a team, the author will make reference to the relevant stages. Tuckman's (1965) stages are no more than a tool to describe where the team is at in its development, (see Chapter 2 for a full description of Tuckman's (1965) stages of team development),[12] but like all abstract concepts it is difficult to transfer this to the written word.

In reality, the team travels along a development continuum, but not necessarily always forward. Teams are made up of people held together by relationships which are in themselves complex processes and teams may be said to develop by moving through the different stages but, from time to time, may revisit a past stage as they face new circumstances. A visual illustration of this idea is of a ball travelling backwards and forwards along a road made up of several stages, as seen in Figure 2.1 of Chapter 2. An

[12] For the purposes of this study, the author omits stage 5 'Adjourning' that describes the break-up of the group. Its purpose fulfilled, the Abbey MGP is now a permanent feature of the local maternity service.

example of this can be found when the Abbey midwives had to adapt to new members joining the team. At this time they were in the 'storming' stage but, in accommodating the new members, they returned to the behaviours described in the 'forming' stage. Thus, to have any utility in helping us to understand the team processes, the model needs to allow for descriptions of the team re-visiting stages as they move along the continuum.

One of the consequences of the political agenda at the time was that the success or failure of the pilot MGPs was to be used as evidence on which to base the decision about whether to convert the entire maternity service to MGPs, but this was later halted due to the changing local political and financial agendas. The two MGPs now remain established, but in isolation. The penalty is that a 'them' and 'us' culture has developed between the MGPs and the hospital staff. As mentioned in Chapter 2, there is little research literature available on this type of development in midwifery, therefore the author offers her observations of this phenomenon gathered during this study.

Davis *et al.* (2006) concur with the author that the asset of using ethnography as a method is that observation of actual events leads to highlighting previously unknown phenomena, which can be particularly illuminating in the case of documenting the implementation of new policy initiatives. The narrative that follows has been arranged in strict chronological sequence in order to give some sense of time and the team development process.

Setting up the team

The Abbey MGP was never a 'natural' team that self-selected its members. They did not choose to come together. The original nine members were selected by a team of

managers from Midwifery and Human Resources and the main criteria was that they should live in, or near to, the geographical patch they cover. As stated in Chapter 2, the patch is a large one, mainly rural with a number of small villages, hamlets and a market town. The Trust management expressed concerns that the vast mileage to be covered could compromise the safety of the on-call cover. This led to the decision that only staff members living in, or near to, the geographical patch would be recruited to the team. This group of individuals did not know each other and most of them had never worked together. Both traditional community and hospital midwives were represented in this team.

Pay Scales

Originally, all community midwives were graded at 'G' grade and the hospital midwives at 'E' grade. The Trust negotiated that the minimum grade for all its midwives would be set at 'F' grade and all members of the MGP would go out on the 'F' grade. This did mean that some 'G' grade posts were demoted to 'F' grade, but because of their time at 'G' level these staff benefited from a protected salary for a given number of years. Staff negotiated that the post of Group Leader for the MGP would be rotational on a yearly basis and, in recognition of the role of the Group Leader, set the pay scale at 'G' grade. This would allow all members of the group to experience the role of Group Leader and benefit from the extra remuneration. Thus, the Abbey MGP was made up of one Group Leader (at 'G' grade) and eight midwives (at 'F' grade). Though accepted by all members of staff at the outset, pay scales and leadership issues proved to be a subject of contention at times between the members of the group. The two community midwives (who were originally working in the patch) lost their 'G' grade (but retained their protected salary) and the hospital midwives making up the Abbey MGP moved from an 'E' to and 'F grade, thus gaining promotion.

Thus, for some members there was a perceived loss of status, whilst for others there was a gain.

The members of the 'B' MGP (Team 'B') self-selected. They all originally worked in a hospital, so therefore were all equal in status. They knew each other very well, both at work and socially. All members of this group had the same salary grade. Their geographical patch was in the town, incorporating the local garrison. They worked very close geographically to the main unit.

In search of an identity

During the four months leading up to the date of 'going live as a team', the maternity services management agreed that the members of the Abbey MGP could meet for three hours each week. This time was used to allow the members of the group to get to know one another and to plan how they would put into practice the ideas set up to implement the pilot scheme. One of the first issues considered by the group was the name or designation they would like to use. The pilot scheme called for two groups to go out, but the Abbey MGP was the first identified and it therefore fell to them to select the terms to be used.

This was an issue that was debated by these midwives over a period of approximately four weeks. The issue of names for them was divided into two main debates. The first and most contentious was whether to use the term 'team' or 'group practice'. The debate was intense, passionate and was not solely confined to the members of the group/team, but embraced the entire maternity service. It seemed as if everyone had an opinion. The group felt, however, that the final decision was theirs to make. The second issue was the exclusive name of this group. In contrast, the debate was brief and the

final choice of name ('The Abbey') was based on a local landmark. In order to preserve anonymity the author has selected the name 'Abbey'. The importance of the terms used to describe their practice was clearly an issue which the midwives felt had powerful implications for their future identity, and the following comments taken from the interviews during the first six months reflect this:

> *"Team midwives means we belong to the main group, the hospital, we want to be independent. We want to be seen to be different from community midwives."*
> (Abbey midwife)

> *"We want the GPs to take us seriously. The name is important."*
> (Abbey midwife)

> *"Midwifery Group Practice conjures up the similarity with a doctor's practice."*
> (Abbey midwife)

> *"Midwifery Group Practice shows we are a distinct unit from anything else on offer in this area."*
> (Abbey midwife)

> *"Midwifery Group Practice is used by independent midwives working together, so we can be the same."*
> (Abbey Midwife)

This identifies that, from the earliest days, this group felt a need to establish their identity as different and/or separate from what was currently on offer within the maternity service. The author was interested to consider the importance that status had at such an early stage of the development of the MGP. The group expressed a need to be seen or identified as having equal status to the General Practitioner.

In searching the literature, the author has discovered that the terms 'teams', 'team midwifery' and 'Midwifery Group Practice' are used interchangeably in midwifery. These terms, however, conjure up different concepts. The term 'team' signifies a group

(any number) of like-minded people - a very loose definition.[13] 'Team midwifery' places the group within midwifery, but once again seems to encompass a great variety of definitions (any number, hospital-based, community-based, combination of both, etc.). For the author, the term 'group practice' implies a group of practitioners with the autonomy, responsibility and accountability that this entails. The Cumberlege Report (DoH, 1993) highlights that "private midwifery group practice demonstrates a high quality practice and the most complete continuity of carer" (author's emphasis). Here, the term 'group practice' is used by independent midwives and utilised in the Cumberlege Report (DoH, 1993) as an example. The following quotation reflects on the differences of these two concepts and clearly defines them for the profession:

> "I advocate group practice rather than team midwifery. The main difference between the two types of practice is that group practice involves a small number of midwives who carry a caseload, whereas team midwifery can involve much larger numbers of midwives and may be purely hospital based. Group practice moves forward from the idea of team midwifery in that it implies the organization of a practice, rather than simply a shift of ward-based or community based staffing. This is a fundamental difference" (Page, 1995, p.13).

Midwives have long been striving to regain their status as autonomous practitioners, as argued by Donnison (1988) and Tew (1990), and the members of the Abbey MGP felt very strongly that their denomination should reflect this. They also clearly saw an opportunity to become responsible for more than just covering staff responsibilities, and developing their own version of midwifery practice. Thus, the choice of 'Midwifery Group Practice' signifies a claim to both this independence and the status perceived to be attached to the GP's practice. The Trust adopted the term 'Midwifery Group Practice', with the proviso that each subsequent group would select a name that would identify them.

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[13] *Chambers Dictionary*, Kirkpatrick (1883), page 1327.

The second team to 'go out' with the Abbey MGP as part of the pilot study also chose a local landmark to use as their name. For the purposes of this work and preserving anonymity, the author has designated them as the 'B' MGP (or, more usually, as Team 'B').

Cars

The Abbey MGP recruited midwives from the community and hospital environments. The two community midwives already employed in the area had worked in that geographical patch for many years and both had a 'lease car' from the Trust. The management of the Trust needed to provide cars for the remaining members of this group and also for the midwives of the second group to go out. A fleet of cars was leased by the Trust. Midwives joining the MGPs were given a choice: to use the cars for 'work purposes only' or to register using the cars for private mileage. The Trust would charge these midwives a set sum per private mile used. It was also agreed that the current leasing arrangements with the two community midwives would stand. This created a problem. The fleet cars were small and basic models. The midwives had no choice. The lease cars used by the community midwives were much larger, more comfortable and these midwives had the opportunity to choose the model they wanted. This became a major issue for the members of the group and significantly delayed the cohesion process. Here are some examples of the comments made at the first interviews.

> *"We should all have the same* [car]. *It's not fair that some of us have to manage on such a basic model".*
> (Abbey midwife)

> *"Living on the farm and in such a rural area I would like to have a Land Rover, that would help out with work and family. We have no choice. It's not fair."*
> (Abbey midwife)

"The thing they don't realise is that there are expenses to a lease car, we have to pay more tax."
(Abbey midwife)

"Why should we change if we are already within the lease car contract with the Trust. I know they want us all to be the same but such a small car would not be enough for the family to use. I need the car to use for work and family. I don't want to change."
(Abbey midwife)

The controversy over the cars was taken up by the midwives' partners (husbands). During the first months of the new working arrangements, most of the midwives reported that their partners (husbands) were complaining that the long hours worked impinged on family life. When challenged by the midwives that they (partners, husbands) often worked long hours, the justification was that they provided the 'company car' for family use. It seems though, that these men did not perceive the small, basic model car as a perk of the job, nor valued it as a contribution to the family standing. This was revealed during a social gathering, where the author had the opportunity to converse with a group of the Abbey MGP members' partners and this topic was discussed at length.

"Yes, I often work long hours and I am often away from home but I have a nice big comfortable family car for domestic use. Those cars are so small that it only serves for school runs or shopping."
(an Abbey MGP partner)

"The company car contributes to the family."
(an Abbey MGP partner)

"There is no status in those things [cars]*, the girls should get more for their efforts and long hours."*
(an Abbey MGP partner)

The support and contributions to the debate made by these partners served to polarise attitudes within the group and hindered team relationships during the first six months.

The issue of the cars has now been settled, as the community midwives have retired. The subject of the cars was mentioned throughout the period of data collection, but tended to be referred to in conjunction with the grading issue, as it affected the same individuals (the community midwives not only retained their lease cars but though re-graded as 'F' grade had many years of protected 'G' grade salaries ahead). The importance of 'fairness' and a perception that all members share the same status was extremely important for the team building processes - clearly, if members were expected to contribute the same amount and quality of work, it was difficult to create a sense of equality and co-operation if divisions of status and reward already characterised the team. This is a point which will be returned to in the conclusion.

All members of Team 'B' had the small basic models leased by the Trust for this pilot study, as none of them had a previous lease car arrangement. They also had a choice of the use of private miles. This group set out on an equal footing in relation to a number of issues, including previous experience, pay scales and cars, and it seems reasonable to assume that this level of commonality contributed significantly to the rapid integration and bonding of team relationships which appeared to be evident in this team.

Birthing centre

For practical and administrative reasons, the Abbey MGP had to have a 'base' where they could carry out their work, store equipment and hold meetings. Their geographical patch was so large that the central market town was sixteen miles away from the main unit. In consultation with local GPs, who felt very uneasy that more home births would follow the setting up of the MGP, the Trust agreed to convert three rooms at the local Community Hospital (an old cottage hospital) into a Birthing Centre. This centre would not have any allocated staff on duty. The Abbey MGP midwives would meet their

women at the centre and, after delivery, mother and baby would go home. The midwife would follow the woman home to 'settle in' the new arrival.

In an emergency, the midwife would summon an ambulance with paramedic support and transfer the woman to the main obstetric unit. In spite of the fact that there would be no doctor on duty either in the Community Hospital or the Birthing Centre, the mere fact that the Birthing Centre was contained within a 'hospital' was sufficient reassurance for the local GPs and allayed their fears (Tew, 1990). As referred to in Chapter 2, doctors feel comfortable working in the familiar environment of a hospital (Tew, 1990). Soon after the meeting held to inform GPs of the proposed pilot teams, the author made the following field notes:

> *The GPs were very defensive during the discussions and did not welcome the proposed changes from traditional community midwives to MGP. They immediately stated their opposition to home deliveries and the discussion moved on to where the MGP would be 'housed' or have a base.*
>
> (field notes, made after the meeting between Head of Midwifery, local GPs and the author)

> *It was the GPs who suggested the use of a room in the local Community Hospital where they all have elderly patients. There is no doctor on the premises and the nurses call the relevant GO during office hours and the on-call GP during out of hours.*
>
> (field notes, made after the meeting between Head of Midwifery, local GPs and the author)

> *The fact that these GPs were in opposition to the idea of establishing an MGP in their area but felt able to accommodate the concept so long as the MGP could function based at the hospital, is a clear illustration of how attached to the hospital environment doctors are. The Community Hospital was perceived to be a safe environment just because it was a hospital, regardless whether a doctor is present or not.*
>
> (field notes, made after the meeting between Head of Midwifery, local GPs and the author)

The name (Birthing Centre) was selected to indicate that it was an alternative to home birth, though the selection criteria for women would be the same.

The Abbey MGP now had a 'base' that was central in the patch. The Birthing Centre has a kitchen, office, staff toilet, birthing room with en-suite shower/toilet, and large meeting room. The midwives from the Abbey MGP were very involved in decorating and setting up the Birthing Centre. They personalised it and made it 'their territory'. From the very outset it was 'their project'. The author was able to observe this sense of ownership as they worked very closely with the local League of Friends and were able to obtain equipment and comforts not available in the main maternity unit.

This ability of the Abbey MGP to access additional resources often caused comment from their manager at meetings when Abbey MGP members were not present.

> *"I do not see why the Abbey should have* [item] *when I can't get the funds for the community to have the same."*
> (midwifery manager)

> *"It seems they can have what they want at times."*
> (midwifery manager)

This was neither well received nor accepted by staff in the main unit. The author is of the opinion that this is one of the factors that has contributed to the 'them' and 'us' divide which has emerged between the Abbey MGP midwives and other staff, and which is described in more detail later.

Friedson (1994) highlights the fact that professional work is by its very nature perceived as discretionary, but that professional autonomy within a bureaucracy is governed by resource constraints. Thus, the author has observed just how the Abbey midwives, physically removed from the hospital and therefore also remote from direct management constraints, have conspired to find their own resources to achieve a desired

goal, but this demonstration of autonomy in turn created problems with their relationships with management and their hospital colleagues.

Team 'B', by contrast, covers the garrison and surrounding patch in the main town, a few minutes away from the main unit. They started using the Community Midwives Office as their 'base', but after a year campaigned to have their own separate 'base' within the patch they covered. They do not, however, have a Birthing Centre. They have the use of two offices in a local Health Centre. As they are so close to the main unit, they undertake all the care for their women and are far more visible to the hospital staff than the Abbey MGP who, because of the large rural patch and the vast mileage to cover, need assistance from the hospital staff to undertake some of the care of their women.

Team 'B' appear to have integrated into a cohesive group far more rapidly than the Abbey MGP achieved in its early days. The author has observed that Team 'B' are perceived by management to be far more efficient, autonomous and cause less trouble. The following notes made after an informal managers' meeting illustrate this point:

> [S] *said that Team 'B' work very well together, but Abbey are constantly arguing with each other.*
>
> (field notes made after managers' meeting)

> [S] *is of the opinion that of the two MGPs we have out there, Team 'B' is far easier to manage: they just get on with it all, they do not come to me for much. Abbey on the other hand need a firm hand or they are off 'doing their own thing'.*
>
> (field notes made after managers' meeting)

The author has noted, however, that Team 'B' did not develop the same strategy as Abbey to acquire resources. They went to management for their requests, at least at the beginning. This changed later, once they were established and well known in the Army barracks. The Army did a lot of fundraising for them and, just like Abbey MGP, they

acquired their own extra equipment. Interestingly, the contribution of the Army to the resources of Team 'B' has been perceived by management and colleagues as no more than a grateful acknowledgment of the work done by Team 'B' for the Army. Therefore, it has not generated the same response as that experienced by the Abbey midwives.

Allocating the work

The original concept was that the geographical patch of the Abbey MGP would be divided into a small area for each midwife, each area containing approximately forty pregnant women. As the pregnant population could not be anticipated, the boundaries would of necessity be flexible, so that no one individual midwife would be overloaded whilst the rest of the group languished in boredom. The Group Leader would ensure that the allocation was carried out in a fair manner. Allocating the individual geographical areas presented a problem. The members of the group who had been community midwives already had their established areas and were not prepared to change them. The following comments are derived from interview data of the Abbey MGP midwives who were community midwives:

> *"I know the area, the women, the GPs and I do not want to lose that."*
> (Abbey midwife)

> *"This is all new, I need to have some stability!"*
> (Abbey midwife)

> *"We have worked here for years and now the new ones come out and want to take everything away."*
> (Abbey midwife)

The Abbey MGP midwives whose work was previously based in the unit commented thus:

"...they are too established in that area, a move would be better for all of us, we could all start from the same base line."
(Abbey midwife)

"Their ways are old fashioned and they need to change, so moving area and GPs would be of benefit not only to them but all the group."
(Abbey midwife)

"They talk about overwhelming change but then, if you think about it the change is far more drastic for us coming out away from the hospital."
(Abbey midwife)

The risk was that the team would split into two opposing groups based on their pre-existing role and territory. One of the GP surgeries made representation to management, demanding that the midwife who had worked there for fifteen years should not be moved. Another influencing factor was the fact that midwives from neighbouring 'patches' would pair up in order to provide on-call cover. As these midwives did not know each other, the allocation of the individual geographical 'patches' was also influenced by who the neighbouring partner was. After a great deal of discussion and debate (lasting approximately 4-6 weeks), the Abbey MGP decided that this issue was threatening their very existence and agreed to divide the area, accommodating the ex-community midwives' requests. The author's verdict is that when setting up the Abbey MGP, some midwives felt that they faced too many fundamental changes simultaneously, therefore they expressed the need to retain an element of continuity with the work environment they were familiar with. It is worthy of note that the group were prepared to negotiate and compromise in order to preserve its existence. Motivation to succeed provided the drive to compromise. Dickson illustrates this aspect of team development, stating:

"At the formative stage of team development team members will be wary of each other and communication is limited. When team members don't know each other well, this can lead to

> misunderstanding and a very uncomfortable stage for the members of the group" (1998, p.15).

This concept dovetails comfortably into Tuckman's (1965) 'forming' stage (see Tuckman's model of group development, detailed in Chapter 2), although it is also necessary to recognise that the disputes and debates over differences that were inherent to the foundation of the team could also be seen as containing elements of the 'storming' stage of group formation. This highlights an important consideration for the utility of Tuckman's model, inasmuch as it is important to recognise that two (and possibly more) stages of team formation can be evident at the same time in the same team. In the case of the Abbey MGP, it is likely that starting from rather unequal positions meant that a certain amount of internal negotiating had to be completed before all could feel equally committed to the joint project of 'forming' the team. Once again, this offers a possible rider to Tuckman's concept of team formation, as we note that if all team members join with equal status and privileges it is more likely that the model will be applicable.

Over the years, the Abbey MGP has seen many changes, not least that the midwives themselves have changed. They are getting to know each other very well. Some have left and others have joined the group. At such times, the group has evolved a policy of re-allocating the areas. This is done with the agreement of every member. The consensus from the group now, in contrast to the original claim that they wanted to hold on to existing territory, is that it would benefit everyone to experience different areas. Dickson reaffirms this:

> "Team members grow to accept that a difference of opinion is inevitable and also a positive attribute. It is often at this stage that the ground rules or values are defined so that the team can make the most of team members' strengths and perform most effectively" (1998, p.15).

So, with time and agreement, what started out as a threat to the group has, in fact, developed into acceptance and harmonious working relationships. It seems likely that as the midwives were able to develop an identity based firmly within the team, rather than derived from the GP practices with whom they had previously worked, they were able to sacrifice the status attached to 'territory' in favour of 'team membership'.

Team 'B' did not encounter this problem. They were all from the hospital and the division of the patch was made easy because the Abbey MGP had pioneered the way forward. Allocation of each geographical area proved to be uneventful for this group. In Team 'B', where all members started on an equal footing, the forming stage seemed not to include the elements of 'storming' which were evident in the Abbey MGP.

Holidays

During the first few weeks of existence, the members of the Abbey MGP had to grapple with the issue of holiday allocation. Management had delegated this task to the group. It took a great deal of negotiation, diplomacy and compromise to accommodate each member's requests. The diverse individual needs created some conflict when requesting leave at peak school holiday times. The members of the group who had schoolchildren expected this fact to be accommodated by those with no children. They, in turn, felt that they had family commitments too, and were entitled to an equal share in the holiday allocation. This was the first time that the members of the group had to confront and resolve this issue. Whilst they were part of the larger groups of community or hospital midwives, management had allocated holiday leave. Once again, the issue of 'fairness' was central to the disagreements. The following comments illustrate the conflict faced.

> *"It's not fair! Just because you have children, you can expect to have Christmas off. I have family I wish to share this time with but it is assumed that I don't mind."*
> (Abbey midwife)

> *"I cannot take the children out of school so... I have to take... in the school holidays."*
> (Abbey midwife)

> *"My husband is a teacher and school holidays are the only time we can have together."*
> (Abbey midwife)

> *"I would give up school holiday times except for the festivals* [Christmas, Easter], *but once again the issue of school holidays and children is used as ammunition."*
> (Abbey midwife)

Blair (2000) (as described in Chapter 2) translates Tuckman's (1965) definition of the 'storming' phase of group development thus:

> "Storming is the stage when all Hell breaks loose and the leaders are lynched. Factions form, personalities clash, no-one concedes a single point without first fighting tooth and nail. Most importantly, very little communication occurs since no-one is listening and some are still unwilling to talk openly."

This was clearly evident in the evolving group dynamics of the Abbey MGP members.

The midwives from Team 'B' were also undergoing the same process of group development described in Chapter 2 and, although conflicts were less marked or less public, they still existed.

Students

The Abbey MGP has midwifery students allocated to them. They spend their first allocation, lasting six months, with the group. All students introduced to the group have requested to return for their second allocation in the community. It thus seems to be very popular with students. They are allocated a member of the group as their role

mentor, but also accompany other members. These students participate in all aspects of the care delivered to the client group and also involve themselves in the group's social activities. Feedback from the students suggests that they feel this introduction to midwifery is a valuable asset to them. It gives them good all round experience, which also includes home births. The students comment that this exposure to what they describe as 'the midwifery model of practice' gives them a point of comparison with the medical model endemic in hospitals. The midwifery lecturers comment that:

> *"You can tell students that have been out with teams or MGP - they have gained so much confidence."*
> (midwifery lecturer)

> *"It seems to have prepared them* [the students] *for the traumas of the Delivery Suite. They seem to remember that there is an alternative and not all births are managed under medical care."*
> (midwifery lecturer)

The author would comment that exposing students to vastly differing cultures throughout their studies grants them the opportunity to not only experience an alternative to the medical model of maternity care, but challenges them to develop their own view of the important/essential elements of the practitioners they wish to become. The midwives of the Abbey MGP are very keen to accept students; they are seen as the future of midwifery and this is an opportunity to promote the concept of MGPs for the future. At the time of writing this thesis, the author can report that a small number of women who have experienced the Abbey MGP as a model of midwifery care have now embarked on a career in midwifery.

Conclusion

In this chapter we have seen the start of the journey that the Abbey midwives have embarked on. In these early days we see the team go through Tuckman's (1965)

'forming' and 'storming' stages. These are the early hesitant and difficult stages of the journey where feelings and boundaries are explored. As we have seen, during this early time these midwives were focused on their own issues (holidays, cars, etc) and did not base arguments or disputes around the women they would be caring for. During these early exploratory stages the women and their care did not play an important role in team or individual discussions.

In the following chapter the author will describe the later 'norming' stage, which included the development of a significant alliance with the women and a recognition that the women provided a vital resource in terms of legitimation of autonomous practice and personal validation, which the midwives experienced as empowering. The author will argue that discovering the powerful ways in which the women offered an alternative means of support, greatly facilitated the development of autonomous practice during the later part of the journey. Therefore, in the next chapter, the author focuses on the journey towards autonomy for this group of midwives.

Chapter 7

Developing Autonomy

Flexible working

One of the basic principles that motivated the change to organising MGPs was the concept of providing 'continuity of carer'. In order to provide this, the midwifery service would have to change the way in which the work was organised and delivered. Since the 1950s, when birth was moved to the hospital environment, midwives have primarily worked a shift system. This has advantages: the shifts are early, late or night and the working day is shorter (seven and a half hours). Community midwives work a nine to five timetable and provide an on-call service for out of hours emergencies. Duty rotas are set up and the individual member of staff has a clear indication of the work time required.

The disadvantage is that the service provided has become disjointed. The maternity service does not have a steady predictable workload. The work demands can be almost overwhelming on one shift, while the following shift may be so quiet that boredom threatens. Midwives often find themselves involved in a crucial moment of the delivery process at the end of their shift, so they do not leave on time. Each area is provided with a standard minimum number of staff for each shift, regardless of the actual workload involved. At peak times there are not enough staff to provide a safe, caring service, while at quiet times staff are sitting around with nothing to do but complete the shift time. Ball *et al.* summarise this idea by saying:

> "Babies are not conceived nor born according to hospital rotas. Fluctuations in workload would be best met by a more mobile service in terms of availability of time and location of need" (1992, p.7).

The Abbey MGP had to organise the provision of service to the women in their area. They no longer had the constraints of shift hours, but they also lost the familiarity of this working pattern. Some grave concerns were expressed by all staff as to the feasibility of working a flexible timetable. Particular concern was expressed by midwives with young children. The Abbey midwives developed a rota that demonstrates who is on duty from nine to five and who is providing the on-call out of hours service.

Each Abbey midwife has to provide care for forty women in her area; of these, an average of four are expected to deliver their babies each month, the rest have antenatal and postnatal visits. The only part of this workload that is totally unpredictable is the delivery of the baby; therefore, the Abbey midwives can arrange their average day to suit their particular needs. The women are informed and understand that all visits are subject to re-negotiation due to deliveries, but because they all benefit from having a midwife they know, they accept this flexibility very well.

The Abbey midwives now have control over the majority of their work time. Some individuals prefer to work mornings and the only times they are seen working evenings or nights is for the delivery of a baby. Others prefer to start later in the day and work primarily in the evenings. Children are taken to and/or picked up from school and work visits done. Some days the list of visits is long and the hours are many. Conversely, there are others when there is only one visit to be made.

The hours actually worked are carefully accounted for and entered on the monthly time sheet.[14] Statistics demonstrate that the hours average out within the year. The Abbey MGP incorporates meeting times, clinic times and parentcraft teaching times into their

[14] These were developed specially by the Finance Department to record the actual hours worked and not the usual shift hours.

schedules. As will be seen when discussing work allocation, this flexibility allows each midwife some control over the organisation of her work.

After six months, the Abbey midwives were beginning to settle into the new way of working. Blair defines groups in the work context by stating that:

> "when people work in groups, there are two quite separate issues involved. The first is the *task* and the problems involved in getting the job done. Frequently this is the only issue which the group considers. The second is the *process* of the group work itself: the mechanisms by which the group acts as a unit and not as a loose rabble" (2000, p.2).

Thus, the author suggests that the Abbey MGP was at this stage experiencing the 'forming' developmental sequence of group development, described by Blair (2000) and Tuckman (1965), and referred to in Chapter 2. The disagreements between members which were evident and described earlier can be conceptualised as part of the process by which members derived mechanisms for acting as a co-ordinated and team-like unit, and can legitimately be compared with the 'storming' phase of development.

The changes in work allocation

During the time that data collection was being undertaken the author identified changes, sometimes very subtle, to the way in which the work was allocated. The original idea was that each midwife would care for the women within her individual geographical patch. It was the Group Leader's responsibility to ensure that the allocation of women was equally distributed to the group. This strategy worked well for the first year.

The author noticed at team meetings that some midwives would request consent from the Group Leader and their colleagues to continue to care for a woman who had moved house out of their individual patch. This was always agreed and justified as adhering to

the principle of continuity of care. As time progressed, the requests were more varied. Such as:

> *"She had a miscarriage last time and I got to know her."*
> (Abbey midwife)

> *"I cared for her sister and she would like me to care for her."*
> (Abbey midwife)

> *"I delivered her last baby..."*
> (Abbey midwife)

> *"I know her..."*
> (Abbey midwife)

> *"I have met her before so..."*
> (Abbey midwife)

> *"She is one of mine..."*
> (Abbey midwife)

Another development noted was that some women moved out of the area and were to be cared for by the neighbouring Trust's midwives. Not only did the women request that they continue under the care of 'their known midwife' (the Abbey midwives) but the midwives themselves actively encouraged this by recommending that the women write to the Head of Midwifery requesting continuity of care. The first few were accommodated with no problems. However, the numbers increased and management felt that the Abbey MGP's workload was in danger of overload, not to mention the financial implications of this cross-Trust border care allocation. This was further exacerbated as the Abbey MGP became well established and its reputation became known by the local population. Women from neighbouring Trusts were frequently requesting that they be cared for by members of the Abbey MGP. Therefore, management imposed a strict observance of the Abbey MGP's boundaries. The midwives of the Abbey MGP voiced their regret at losing these women to other

midwives, even if it was to colleagues in their Trust. The following comments illustrate this point.

> *"I know she has moved but only four miles away. It is such a shame that she has to go through the rest of pregnancy with strangers caring for her."*
> (Abbey midwife)

> *"We can't help being very popular, I don't understand why management will not allow us to continue. We want it, the women want it."*
> (Abbey midwife)

> *"If she* [the woman] *is prepared to come here, then I* [the midwife] *am prepared to undertake her care."*
> (Abbey midwife)

Midwifery management made the decision that the formal Trust boundaries and the Abbey MGP borders would have to be adhered to in all circumstances. As highlighted above, this decision was very unpopular with the members of the Abbey MGP. They made their feelings very clear to management, but to no avail. However, some of the women resorted to stealthy means of achieving their desired outcome. Once they had moved out of the area they visited relatives within the Trust boundaries for all appointments with the midwife, GP or consultant. Unknown to management, the midwives from the Abbey MGP not only supported and encouraged, but aided and abetted, this strategy.

This study reveals just how strongly the woman-midwife relationship developed within the MGP context. Women and midwives were able to collude against the edicts of management to achieve their desired outcome, and they developed a number of strategies for accomplishing this, including providing the addresses of relatives or friends as their own, in order to accommodate the strict boundary rules which were put in place. There is no evidence in the literature of collusion between midwives and the

women they care for, except the work done by Curtis (1991), where she observed midwives avoiding potential conflict by controlling the information given to doctors in order to prevent total medicalisation of birth. The author has personal experience of this phenomenon, as the culture of midwifery uses the time honoured tactic of 'waiting for the head to come down' before formally acknowledging full dilatation. During the early days of the author's clinical practice, one of the consultants working in the unit sent a memo stating that all 'his' women should have an ARM (artificial rupture of membranes) performed at 3 cm dilatation. The author and her colleagues ensured that the women in their care would only have a recorded dilatation of 2cm or 6cm, never 3cm. This strategy has its roots in ancient history, as we read in the Bible that:

> "The King of Egypt spoke to Shiphrah and Puah, the two midwives that helped the Hebrew women. 'When you help the women give birth' he said to them, 'kill the baby if it is a boy: but if it is a girl, let it live'. But the midwives were God-fearing and so did not obey the king, instead they let the boys live, So the king sent for the midwives and asked them 'Why are you doing this?' 'Why are you letting the boys live?' They answered: 'the Hebrew women are not like Egyptian women, they give birth easily and their babies are born before either of us gets there'."

The use of this strategy demonstrates one of the informal methods by which the Abbey midwives have gained increased control over their work. Although this could certainly be described as covert manipulation of the working system, it was also clearly justified by the midwives on the grounds of meeting the women's needs. The 'rules' were interpreted by the midwives to meet the both the women's and the midwives' needs, and this was always justified by the need to achieve continuity of carer. This offers an interesting example of the ways in which policy directives are interpreted flexibly by workers at the 'coal face' of service delivery, thus policy is implemented in ways which often bear little similarity to the original intention of the policy makers (Lipsky, 1983; Miller, 1991; Hunter, 2002).

I see them [Abbey midwives] *exchanging booking forms, discussing who should have this particular lady. This should be strictly geographical but this is disregarded by them all. They chat very vigorously about the 'need' to care for 'this woman' because they know them. They are laying claim to their personal caseloads.*

(field notes made after a team meeting)

Discussion after team meeting about Mrs B requesting Abbey midwives' care. She has written to management. Request denied as now living out of area. Mrs B therefore, writes to management to say she is remaining in the area for Abbey midwives' care. Mrs B uses her mother's address. Abbey midwives plan the visits to this address. The midwives are happy with this arrangement.

(field notes made after a team meeting)

Interesting to note the degree of conspiracy and collusion that exists between the women and these midwives. The relationship is so strong that it empowers both groups to gain some control over the circumstances they are facing.

(field notes made after a team meeting)

Over the years that this study has encompassed, the way in which the allocation of work is managed has changed. The Group Leader still has the official designated responsibility of assigning the individual women to each midwife, but in reality she only has responsibility for ensuring that there is an equitable distribution of the workload. Each group midwife selects the women she will care for. This is negotiated with colleagues and agreed with the group. This patient selection/allocation mechanism contributed to the evidence to support these midwives in their attempt to negotiate re-grading (the current 'F' grade to 'G' grade) of their professional expertise. This was successful and the midwives constituted one of the first groups nationwide that achieved a 'G' grade for all its members (further discussion follows).

It is clear that the strategy of supporting strong relationships with the women they care for has allowed the midwives to feel far more confident about their own practice and to value it in a way that empowers them to seek recognition for the benefits of that practice within their own profession, and externally within the NHS. Their journey to

autonomous practice as midwives who are truly able to be 'with women' appears to have reached a comfortable destination, both for the midwives and the women they serve. However, the strained relationships with 'management' demonstrate the difficulties which autonomous practice creates for bureaucratic systems.

The value and strength of using ethnography is that it offers the author the opportunity to observe and comment on this behaviour. This covert behaviour is highlighted as a result of direct observation, as illustrated above in the author's field notes. This element of collusion between the service providers and recipients demonstrates the difference between the institutional or organisational vision of service provision that, as highlighted by Sharp (1998), "promotes the accomplishing of good through policy development and management decisions". In contrast, midwifery practice, according to Sharp (1998) "achieves good through direct interaction with the women".

This demonstrates the difference in implementing a policy that is perceived by management as necessitating adherence to strict geographical boundaries and the conspiracy between the midwives and the women to achieve a desired outcome, in this case, continuity of care. This behaviour forms part of what Lipsky (1983) has called 'street-level bureaucracy', as highlighted in Chapter 2.

> "The decisions of street-level bureaucrats, the routines they establish and the devices they invent to cope with uncertainties and work pressures effectively become the public policies they carry out" (Lipsky, 1983, p.12).

The Abbey midwives have taken the concept of continuity of care from the 'Changing Childbirth' (DoH, 1993) policy document and adapted it to meet both their and the women's needs. It is clear that there are marked contrasts between the version of 'continuity of care' that the policy makers and managers perceived and the version

which the midwives and the women they care for put into practice. Thus, according to Lipsky (1983), it is the Abbey midwives who are the true policy makers. Lipsky describes street-level bureaucrats as:

> "...public sector workers who interact directly with citizens in the course of their jobs and who have substantial discretion in the execution of their work" (1983, p.3).

The implementation of the 'Changing Childbirth' (DoH, 1993) policy is perceived differently by management and the Abbey midwives. Policy ethnography authors such as Pollitt *et al.* (1990), Cox (1991) and Mays and Pope (1995) highlight the contribution they make to the understanding of the policy process (as discussed in Chapter 2). Lipsky (1983) describes how the public sector worker interprets and adapts the policy in order to carry out their work to a standard that satisfies not only the practitioner but also the client. Ethnography has granted the author the opportunity of reporting observed behaviour that illustrates just how the Abbey midwives carry out their work in the reality of working life which may be, at times, at odds with management. In other words, the strength of ethnographic work is that it allows the researcher to observe life as 'it really is' regardless of how management would like it to be or believes it to be.

The issues highlighted above illustrate the empowerment of midwives working in this manner. The midwives in Team 'B' mirror the midwives in the Abbey MGP in manipulating the work allocation and changing the boundaries. The same conspiracy between the midwives and the women has developed. The only difference is that the cross-Trust border problems do not exist for Team 'B'.

Autonomy

Work is one of the basic facts of life. But not everyone experiences work in the same way (Miller, 1981). Life for most women in our contemporary times means juggling

home life with work commitments. For the Abbey midwives, one of the liberating aspects of working in the MGP is that they are able to exert some control over their work, thus allowing them more freedom to achieve a more comfortable compromise between the demands of work and home.

The autonomy to work with no strict shift patterns and to only work when there is a need, has empowered these midwives to extend their autonomy into other areas, such as colluding with the women to achieve a common goal. Thus, according to Miller (1981) the goal is to alter the distribution of power, in this case from management to the midwives and their clients. Haug and Sussman state that:

> "the professional practitioner that is free to establish a close and trusting relationship with an individual that is in need of the service is becoming a thing of the past. In fact given the bureaucratic systems this client not only has to cope with the authority of the professional but also the organizational milieu in which he/she practices" (1969, p.124).

The professional is also limited by organisational imperatives. Authors such as Exworthy and Halford state that:

> "Professionals justify their claims to autonomy and status in terms of their expert knowledge and skills, geared to effective performance of specialized tasks usually linked with the individual's problems. Their actions are based on a trust relationship with clients" (1999, p.25).

The Abbey midwives have claimed an element of autonomy in controlling their work hours/patterns and, as described above, they collude with the women to achieve a common goal. Haug and Sussman (1969) maintain that the professional bodies working within the hospital environment not only draw upon organisational power but also their professional (expertise) power. In the case of the midwives in the Abbey MGP, it is possible to see the ways in which organisational power is greatly weakened when the

midwives work at a distance from the hospital (organisational base). As the MGP midwives developed stronger relationships with their clients and benefited from the effects of trust and the other positive emotional components of their work, they experienced the management associated with the hospital as being constraining of their professional autonomy. They became willing to draw more of a sense of power and effectiveness from the relationships with 'their' women and less from the benefits available to them as members of the hospital staff.

Confirming their role

The Abbey midwives work in the community and have a base away from the main unit, thus they only visit the main unit when they need to attend one of their ladies. As a midwife in this setting, each one spends a great deal of time alone. Each midwife is faced with having to make all the decisions with no colleague immediately available to consult and compare notes with. The following comments gained at interview illustrate this point:

> *"You cannot open the door and ask for help, you cannot go to the desk area and mull over your concerns and 'niggles' about the woman you are caring for, you just have to dig deep and remember all you ever know and discuss things with your lady."*
>
> (Abbey midwife)

> *"I find I discuss things with my lady, even in the labour ward. I seem to have moved away from the other midwives and forget to keep the shift co-ordinator informed. This then gets us as a group into a lot of trouble."*
>
> (Abbey midwife)

> *"The core staff are moaning about the Abbey midwives again. They do not keep the shift co-ordinator informed of the progress of their ladies. I don't know, they seem to keep themselves to themselves as if the rest of the staff don't exist."*
>
> (from field notes, a midwifery manager speaking informally at Managers' meeting)

These statements illustrate the way that, instead of looking to colleagues and midwifery mangers to affirm and validate them in their role as midwives, they have turned instead to the women. This phenomenon has been aided and abetted by the very close relationship developed by these midwives and the women in their care. This group of midwives has moved away from an occupational model that is now entrenched in a hospital-based medically dominated division of labour. They have migrated to a model that more closely resembles the professional practice that is characterised by collegiate support and autonomy that is encountered in medical general practice or law firms (Miller, 1981).

The Abbey midwives have developed the type of model that was highlighted by 'Changing Childbirth' (DoH, 1993) (as described in Chapter 2) as a good example of what should be on offer to the women. These midwives have developed such a close professional-client relationship that it motivates them to provide the very best practice that is possible. Satisfying their client's wishes provides them with the evidence of a good service and personal job satisfaction. Their affirmation and confirmation emerges from this relationship and is the prime motivation for mobilising resources to achieve all the client's needs. This will also be the motivator for colluding with the women against management directives. Hunter (2002) describes this phenomenon as the development of the 'with woman model' as described in Chapter 2. One important aspect of this fundamental change in the way in which midwifery services can be re-organised to put the women at the centre of their work, is the role played by the team. In the case of the Abbey MGP, the team offered its members a loosely coupled collegiate source of professional support and a supply of clients; however, it acted to facilitate woman-centred practice, a value shared by all its members, rather than to hinder it as the hospital, with a firmly medicalised ethos, appears to do.

Changes within the Abbey MGP

When the Abbey MGP was first established they had nine whole time equivalent midwives, two of whom worked a job share, thus they had ten members. These midwives ranged in experience from six months post-registration to twenty four years experience (in the patch). At the six month anniversary, one of the group members had to leave on long-term sickness and requested to change her working hours; thus, she left the MGP. This elicited a great deal of adverse publicity for the Abbey MGP from their colleagues within the hospital and community. Those members of staff who were feeling uncomfortable with the changes proposed, seized this opportunity to broadcast that the concept of working in this 'new' way was not feasible, as a member of the group had requested to leave. Some hospital midwives, perhaps fearful of change, blamed stress and burnout as the prime motivators for this Abbey midwife to leave the group. Unfortunately, this reinforced the 'them' and 'us' attitude between the staff groups.

The remaining members of the Abbey MGP discussed the issues with management and it was felt by all concerned that the work could be absorbed between the remaining members of the group. Only three members were directly affected and the re-allocation of the workload and geographical patch was rapidly assimilated. The group understood very well the individual midwife's reasons for leaving, but felt very hurt and aggrieved when they became aware of the rumours that had circulated in the service. The following comments, gathered at interview, illustrate this:

> *"They are saying she left because we did not support her, as she is newly qualified. That hurts, because I know that not only did I give her support but the others did too."*
> (Abbey midwife)

"When I was in the Labour Ward yesterday [name] *told me that* [name] *had left because she found working with us too stressful, the hours are too long. They just do not understand!!"*

(Abbey midwife)

"They are already saying that working this way does not work."

(Abbey midwife)

"I was told today that we would all give up with burnout. Well, I for one will not give up! I love it!!"

(Abbey midwife)

It's all you hear round the unit. Unit staff are almost jumping for joy that the Abbey MGP is about to collapse. The poor Abbey girls are devastated and seem to be taking this departure very personally.

(field notes)

The relationship between the Abbey MGP and the hospital midwives was never a comfortable one. As mentioned previously, the Abbey midwives managed a very large rural patch. Due to the distances and time taken to arrive at the main unit, management decided that some of the activities involving Abbey MGP patient care had to be undertaken by hospital staff. There was resentment from hospital staff about this, that exacerbated the 'them' and 'us' divide that existed:

"It's not fair, we have to do their work whilst they swan around the countryside. They chose to go out, they should do all their own work."

(field notes, hospital midwife)

"You ring them but it takes them such a long time to come in that we end up doing more of their work."

(field notes, hospital midwife)

Once more comparisons were made with Team 'B' who worked in the town and incorporated the care given in hospital into their daily routine.

The next major change for the midwives in the Abbey MGP was at approximately eighteen months. Two members of the group developed long-term sickness problems and requested to leave the group and return to work in the hospital. This news had a devastating effect on the rest of the group members. Having survived the first departure of a member from the group, they now envisaged the total disintegration of the group:

> *"This is it! This is now the end! They are waiting for us to fail and this is their opportunity."*
>
> (Abbey midwife, from field notes after Abbey team meeting)

> *"We cannot manage without them. How are we going to survive this? This is the end!"*
>
> (Abbey midwife, from field notes after Abbey team meeting)

> *"This is it! Management will now call us in. They will say we have failed, but we haven't because the concept works so very well. I cannot understand their reasons for leaving, we could work together to get through this. Now it's the end and I don't want to want to go back to hospital."*
>
> (Abbey midwife, from field notes after Abbey team meeting)

The hospital midwives also saw this as the demise of the group and therefore the precipitation of the end to the proposed changes in working practice. Those members of staff most opposed to the changes took the opportunity to make capital of this event, in order to motivate a resistance to change.

> *"Well, they'll have to come in now. Told you it wouldn't work!"*
>
> (Hospital midwife, from field notes)

> *"Too much stress working this way. They are burning out. Told you it does not work. They should give up and come in. I don' want to risk all this. I am not going out."*
>
> (Hospital midwife, from field notes)

This had the effect of making the members of the Abbey MGP feel besieged. The following comments illustrate their feelings:

"I don't like going to the hospital. They are all talking about us and that we will soon be going in. I don't want to go back to that [working in hospital]."
(Abbey midwife)

"They are like vultures waiting to see us fail."
(Abbey midwife)

"They would like nothing better than to see us fail."
(Abbey midwife)

The sense of failure is almost palpable. The Abbey girls are very stressed and downcast. They seem to be just waiting to be called in, they profess defiance but I wonder if they mean it and if they would be prepared to fight.
(field notes)

Individual members of the Abbey MGP experienced a great deal of stress during this time. Morale was very low and only their determination to carry on helped them to persevere. This is part of the motivation and perseverance of a pilot study, as discussed in Chapter 2. Exit interviews were undertaken, which revealed that the members that left experienced some difficulty in adjusting to the lack of structure to their working day and found the on-call commitment stressful. The long-term sickness provided them with the opportunity to request a transfer back to hospital working. It is possible that there are characteristics of particular midwives, or of their personal social circumstances, which equip some better for autonomous practice and some better for practice within a more tightly structured organisational environment but, as we have seen, most of the midwives of the MGP remained very firmly committed to the model of autonomous, 'with woman' practice.

The management team felt at this time that, as the Abbey MGP had originally formed part of the pilot project and had proved that the new working practices did work effectively in delivering good quality service to women, they should support the group and maintain both groups until the political agenda allowed the Trust to convert all the

maternity service to working in this way. Had the original timetable for change been adhered to, the entire service would now be working in this way and no comparisons could have been made, therefore this situation would not have arisen. Thus, despite the fears of the remaining team members, the team was not recalled and instead two new members were welcomed to the Abbey MGP.

Concerns were expressed by both the members of the Abbey MGP and the two new recruits. The two new members had worked in the hospital for many years, had considerable experience as clinical midwives and ward managers (at 'G' grade), but had very limited community experience. The new recruits had originally expressed their concerns that the new working patterns were not compatible with their family commitments. However, in spite of these concerns, they both agreed to work in the MGP for six months and then review it. The members of the Abbey MGP were aware of this and equally expressed their concerns that six months would not be sufficient time for the new members to fully integrate into the team:

> *"We are hardly going to get to know them and they will be gone, then we will face all this again."*
>
> (Abbey midwife, from field notes after Abbey Team Meeting)

> *"They already think it's not going to work, so how are they going to integrate into our team?"*
>
> (Abbey midwife, from field notes after Abbey Team Meeting)

> *"They have the hospital* ['them'] *attitudes. How are they going to fit in with us now?"*
>
> (Abbey midwife, from field notes after Abbey Team Meeting)

During the first team meeting with the two new recruits, geographical areas and workloads were allocated and agreed. The two new members stated that they would adhere strictly to policy and would not be available outside on-call hours for any of the

ladies in their caseloads. The rest of the members felt aggrieved that the cohesion of the group was under threat, but they had no option but to accept, because without the new recruits the Abbey MGP ran the risk of folding. The two new members of the group were very cognisant that they were joining an established group. The following statements illustrate this:

> *"I was very worried about working with an established group but they have all made us feel very welcome and we have integrated very quickly."*
>
> (new Abbey midwife, from field notes)

> *"It has taken a little time to get to know everyone and specially how everyone works, their 'little ways', but now I really feel part of the team."*
>
> (new Abbey midwife, from field notes)

> *"I originally was one of 'them' in the hospital who would comment that you can never get hold of an Abbey midwife when you need her. Now I am here as one of 'us' and realise just how far we have to travel and the time it takes."*
>
> (new Abbey midwife, from field notes)

Brill highlights the fact that:

> "It is important to remember that when new team members are introduced there will be changes in the balance of the total team as well as in the individual members" (1998, p.199).

The author is able to report that after a six month settling-in period, two years later, both these new recruits are still out with the Abbey MGP and have totally integrated into the team. They have changed their minds about availability to 'their' women and mirror their colleagues in the group; in fact, they have conformed to the majority view, thus aiding total integration. They have found home and work life compatible.

Team 'B' also had to face the anxiety of a team member leaving after only six months, due to long-term sickness. They have not had anyone else leave since. This group works

physically much closer to the unit and undertakes all aspects of care for their women whilst in hospital as well as in the community. They are seen by their colleagues on a daily basis. Thus, they are perceived by the hospital midwives to be working well and have not endured such a strong 'them' and 'us' attitude divide.

Responsibilities within the MGP

There is a 'Group Leader' nominated by the members of the group, who serves in this post for a year. The administration duties of the group are shared among its members. Some of the 'jobs' are undertaken by an individual who expresses an interest, but others are allocated and then changed so that no individual is burdened with undertaking a task that she dislikes for too long. The group agree that this leads to less conflict. An example of this is the duty rota, as it is difficult to maintain impartiality, cover all duties and grant individual requests.

> *Giving the duty rota to different individuals means they all have the opportunity to appreciate just how difficult it is and it seems to stop infighting.*
>
> (field notes)

The group have capitalised on the interests of some of its members and they can now offer their client group 'aquanatal' classes (antenatal exercises) held in the local swimming pool. The distribution of jobs and group roles undertaken by the members of the Abbey MGP seem to agree with Belbin's findings, that:

> "one mark of winning teams was the way in which members found jobs and team roles that fitted their personal characteristics and abilities" (1981, p.39).

Morgan reiterates this finding by stating that:

> "We all possess many different skills, so most of us would ultimately complete any task assigned to us. But each of us has a different blend of attributes to offer. Sharing tasks amongst

team members in a way that maximises each person's opportunity to bring their strengths to the fore ensures high standards" (1997, pp.50-51).

The group has, however, experienced difficulties. Some members of the group do not enjoy certain activities and these are then perceived as burdensome tasks that are to be avoided if possible, as evidenced in comments made at interview:

> *"I just do not enjoy standing in front of a group of people to talk. I know some of the women, but I don't know their partners. I therefore try and avoid it if I can."*
> (Abbey midwife)

> *"I know it is part of our job, but I just do not feel comfortable doing it. I try and find something else to do."*
> (Abbey midwife)

This leaves the members of the group who do enjoy undertaking the task having to undertake this far more frequently, and resentment can begin to build. The less assertive members of the group feel powerless to insist on a fair distribution of all tasks. Observation has highlighted an element of manipulation of work commitments, in order that certain tasks are not undertaken by individuals who do not enjoy the particular task.

> [A] *is caring for a lady in labour.* [B] *has five visits to complete and will not be available on time.* [C] *is caring for a labouring woman at home and* [D] *needs to be available as a second midwife. Everyone is busy, so* [E] *is called in to help though she is off duty (she likes doing this is the rationale).*
> (field notes)

> *She enjoys doing it but resents having to do it all the time when others seem to be busy. She then feels guilty because the others are very obviously busy. But why her again?*
> (field notes)

> *It is amazing how 'busy'* [A] *and* [D] *can be in order to... avoid parentcraft teaching... or how their 'bleeps' seem to fail just at this time. This manipulation is dangerous as it can create resentment in their colleagues. If the managers knew they would once again suggest that the Abbey MGP is unmanageable when in fact this behaviour is tolerated (even if grumbled about) because each individual manipulates the system in some way to meet their or their women's needs.*
> (field notes)

As commented on above, authors such as Lipsky (1983) describe this manipulative behaviour as the practitioners' (the street-level bureaucrat) strategy for adapting policy to meet their needs and those of their clients. The fact that there were more costs to some individuals than others, compromising the values of 'fairness' espoused by the group, did not serve to deflect the whole team from wanting the group to continue. Clearly the benefits for all concerned of practising autonomously outweighed the disadvantages. The team has arrived at its destination and is now able to take responsibility for organising the division of labour within its own boundaries without outside interference.

As time has gone by, the group has continued to develop and at the third year anniversary the author is able to report that these problems are not so evident, though the subtlety of the manipulation of the workload has increased and therefore is less evident. It is of interest to note though, that now even the less assertive members of the team have joined in the manipulation of work commitments. Gradually, as the group has progressed towards evolving as a team, they are able to discuss most of these issues openly and therefore a more democratic distribution is frequently achieved, reducing resentment and promoting good communication.

Group Leader

During the negotiations between all grades of staff and management of the maternity service in preparation to sending the MGPs out, the post of Group Leader was discussed at great length. It was finally agreed that the individual groups would select their leader. There were benefits to this role; a financial reward for the extra responsibility as designated caseload holder for the group. There was also the managerial role experience

to be gained. Staff felt very strongly that in changing the service to this new working structure, the career advancements for midwives in the clinical setting would be very much reduced. They perceived an unfair advantage for the Group Leader (in gaining management experience), so negotiated that this should be a rotational yearly post. This has been carried out and the group have currently elected their sixth Group Leader.

Management perceive the role of the Group Leader as the person responsible for the total caseload allocated to the group. It is the Group Leader's responsibility to ensure that the number of pregnant women is allocated fairly between members of the group. Administrative duties for the group are also the Group Leader's responsibility. She is also the main link of communication between management and the group. She has regular monthly meetings with her line manager and represents the group at other Trust meetings.

As discussed in Chapter 2, Exworthy and Halford (1999) argue that managers are committed to running bureaucracies, devising rules and enforcing them. On the other hand, professionals are committed to providing expert services and advice. Thus, the Group Leader in this scenario does not fit into either category, but also conforms to aspects of both. As a midwife, and particularly as a midwife located in this team where professional values of autonomy are much more sharply delineated than elsewhere, she is a professional, but as Group Leader she is also part of the management and would be expected to share management values and aims to some extent.

During the first year, the above role description was used and, in acknowledgement of the extra responsibilities and commitments, the Group Leader had a reduced personal caseload of women to care for. Over time, as the group has evolved and new members

have had an input, the role of the Group Leader has changed considerably. The administrative duties are now shared by all members of the group. The responsibility for the group's caseload of women has devolved to each individual midwife and, as highlighted above, each midwife selects the women primarily in her area (but with negotiation can also include others). Group members have therefore assumed most of the responsibilities originally destined for the Group Leader. This leaves the Group Leader with the role as main link of communication between the management and the group. The Group Leader no longer has a reduced caseload. The following comments from the author's field notes highlight the changes in the group's perception of the role of the Group Leader:

> *They feel that they are all 'doing the same job.*
> (field notes)

> *Everyone feels the need to have someone that is identified as the co-ordinator of the group for communication purposes, but the role of Team Leader no longer exists.*
> (field notes)

> *They all feel that the entire group should have the same salary grade.*
> (field notes)

Thus, the author observes that the Abbey midwives are arguing that the Group Leader is still part of the group and not management, they wish to remain independent/apart from hospital management and have devolved the various 'jobs' between members of the group, thus reducing the role to one of communication link between the hospital management/bureaucracy and themselves.

The Abbey MGP has so far experienced six Group Leaders. Each has been very different, reflecting the different personalities. Each year the selection of the Group Leader becomes more difficult. There are individuals who do not wish to take up this role. Some who have experienced the role have stated that they do not wish to return to

it. The opinion of the group is that, in these circumstances, the group would nominate or persuade a Group Leader into a permanent position. Time and group development will tell.

Group Leaders found the role stressful and difficult. At interview they expressed feeling inadequately prepared for the role:

> *"You feel so inadequate for this role. No-one prepares you. You are left to find out for yourself."*
> (Abbey Group Leader)

> *"I always felt that I was in the middle, between the group and management. I found this very stressful, particularly when I could see both points of view."*
> (Abbey Group Leader)

> *"Everything, all of it is 'your fault'. The group, the individual colleague sees it as 'your fault', management see it as 'your fault'. I found this emotionally difficult to cope with.*
> (Abbey Group Leader)

> *"There is no let up. All that time you are the Group Leader, you are carrying not only yourself and all that your personal work has for you but you also take on the group's worries and concerns. As if that is not enough, you also shoulder any extra work or any blame from management."*
> (Abbey Group Leader)

> *"Your colleagues come to you as Group Leader with a host of problems and just 'dump' them on you. They don't even wait for an answer. Their problem is now your problem and they just leave it with you. It's no longer their problem, so now they are free. Even if there is 'no answer' to that particular problem, they just ' dump it' on you. I can't off load it, so I carry it. It is very stressful."*
> (Abbey Group Leader)

The author's observations demonstrate that the Group Leader feels isolated and unsupported, because she does not quite fit into the group nor does she belong to the management structure. This dilemma, as already noted, is highlighted by authors such

as Exworthy and Halford (1999), but also resonates to some extent with the dilemma noted by Hunter (2002) where midwives are caught between two sets of cultural values.

It is evident that the group has shared the administrative responsibilities, but the emotional labour associated with managing issues related to stress or difficulty experienced by individuals is very much left to the Group Leader. When discussing this issue in depth, the Group Leader felt that most of the problems come in three categories. The least in number were the real 'big' problems that the Group Leader could take to the management for answers. The second category, also relatively small in number, are so trivial that they are not worthy of an answer, but because of the 'dumping' effect add to the stress felt. The vast majority of the problems were too trivial to pass on to management, but demanded the Group Leader's attention for the smooth running of the group. The Group Leader felt under pressure to attend to these at the expense of her clinical work. This demand of their attention, time and emotional response whilst attempting to maintain their clinical workload was the primary cause of stress. When analysing this concept with the Group Leaders at data collecting interviews, they felt the stress was due to the 'dumping' effect; the problem was demanding their immediate attention and intruding into their clinical work. The following comments, gathered at interview, illustrate this point:

> *"*[name] *comes along and gives me this problem. She dumps it on me. She is now free to go and do her work. Get job satisfaction. I am left cross and upset because I have to attend to this. To me, it's not my problem but I have to sort it out. I cannot go out to do my clinical work, and even if I do my work, my mind is not free to gain job satisfaction. I am still cross."*
>
> (Abbey Group Leader)

> *"It also works the other way. Management give you a problem for the group to sort out, but as Team Leader you end up doing it and you often feel caught up in the middle between the group and management."*
>
> (Abbey Group Leader)

"I have come to the conclusion that I am not suitable for the Group Leader job, because I need to be liked by everyone and that is not always possible in this role. I find it stressful."
(Abbey Group Leader)

When asked if they would consider a second term as Group Leader, some midwives stated that they would not volunteer again. They strongly recommend that the group should select a permanent Group Leader, not necessarily from its current ranks. The author would argue that these individuals are finding it very difficult to cope with the leadership role because, in their clinical work, they have very clear concepts to deal with, whilst in the management/leadership role they have to cope with ambiguity. Indeed, according to Handy, (1985) leaders "need to have a high tolerance for ambiguity".

Ambiguity is difficult to define and proves to be very uncomfortable for practitioners who are accustomed to defined roles based on clinical knowledge. There is also an issue of lack of management experience, as none of the Group Leaders selected so far have been ward managers.

The role of Group Leader is a difficult one to accommodate for the individual. They are part of the group as professional midwives, but also part of the management structure within the organisation. Authors such as Exworthy and Halford, highlight the dilemma by stating that:

> "Professionals justify their claims to autonomy in terms of their expert knowledge and based on a relationship of trust with their clients. Managers claim their privileges on the basis of institutionalised hierarchical authority. They are agents or servants of corporate bodies rather than individual clients" (1999, p.26).

The claims made on the individual Group Leaders are almost opposing and their loyalties are constantly tested as they often feel an allegiance to both sides, particularly in times of conflict. Observation, however, has yielded the author the insight to confirm that during times of outside threat (possible recall of the MGP) the Group Leader will join the group against management and corporate decisions.

Interestingly, Team 'B' has not developed in the same way. They have maintained the original concept of the role of the Group Leader. The author would argue that the Abbey MGP has developed in this way due to two main factors. Firstly, they are physically removed from the main unit and are not seen by staff and management every day. This has allowed them to gain an element of independence. Secondly, with time, the group has evolved and individuals feel more empowered to take ownership of their work organisation. This empowerment spills over into group work organisation. It will be interesting to see the future development of the Group Leader role for the Abbey MGP. The Trust management could insist all groups are structured in the same way, maintaining the original role of Group Leader. This role may be changed along the lines of the Abbey MGP for all groups, with the Group Leader as only the designated co-ordinator.

The author feels that the Group Leaders in the two pilot groups have endured undertaking the leadership role unsupported, not only from management but also because peer support has been lacking. This may be resolved when the rest of the service converts to MGPs and collegial support may develop.

Sickness record

The Abbey MGP has been affected by sickness, but the vast majority is due to long-term sickness. They have a good reputation for few 'odd days' sick leave. Group members mention that they feel a responsibility to their colleagues and therefore consider very carefully if they will take a day off. The following comments were gathered at interview and illustrate this point.

> *"If I do not feel 100% I still carry on, because you know what the work is and how busy each of your colleagues are, if you add to their problems it's not fair. I try to cut my work down to the minimum to keep going. If I worked in the hospital I would take the day off, there is always someone there to make up the numbers."*
>
> (Abbey midwife)

> *"You know the women, so you have to go, someone else is not the same, so keep going."*
>
> (Abbey midwife)

> *"In hospital you just got on with your work or, if you did not feel fit, you went off sick. You had very little sympathy. Now I am out with Abbey, I work through all but the most severe or contagious sickness, the women are so supportive and sympathetic, your colleagues too, they offer to help and that alone makes you feel better."*
>
> (Abbey midwife)

It seems that all members of the group share a sense of responsibility and take sick leave only when absolutely necessary. This finding is mirrored in the study undertaken by Stevens and McCourt (2002). This aptly illustrates another aspect of the journey these midwives are undertaking towards autonomy and independence. The author has observed that the difference is that once these midwives experience this sense of autonomy, they assume responsibility towards their colleagues and the women, therefore sickness absence is reduced. This sense of responsibility also affects holiday leave. Unless booked to go away or undertake childcare, individual members will either change their holiday dates or not undertake regular duties but will be available to the

group should the workload dictate or if one of 'their' women goes into labour. Time is then claimed back at a later date.

Under threat

During the third year of this project, the maternity service faced a crisis. This crisis served as an excellent illustration of the ways in which team members united against an external threat, putting aside their internal conflicts as they sought to preserve the team itself. The service was providing a two-tier system of care, the pilot teams had proved their worth, but politically the service was unable to convert to the MGP concept. It proved difficult to provide sufficient staff to cover the hospital, community and both MGPs. Managing such a diverse system was proving very difficult. Every attempt was made to convert the service to MGPs, but to no avail. Therefore, the decision was made by the Trust to terminate the pilot and recall the two MGPs.

The Abbey MGP had lived with the uncertainty of existence for three years, but during the last eighteen months a feeling that the Trust had maintained the groups for so long allowed them to hope that they would not be recalled. Thus the decision, when it came, was a shock. The members of both MGPs were galvanised into action. They organised marches and petitions, became very involved with local women's groups and attended numerous meetings. These findings echo the recent work by Walsh (2004), where he describes a sense of collective confidence and a solidarity among staff in the presence of a threat. He describes how staff kept mementos of the marches, rallies and political activities. The Abbey midwives often refer to their 'campaign' and, like the staff described in Walsh's work, the photos and newspaper cuttings are carefully kept and viewed from time to time. The author noted a sense their pride at the successful outcome of their campaign. The threat of recall into hospital also motivated the

members of the Abbey MGP to become totally united. The common purpose motivated everyone to have a united front. All differences, whether great or small, were put aside and the group spoke with one voice. Together they marched with the women and petitioned support.

The political agenda changed once more and, at the time of writing, the author can report that the MGPs are to remain operational, even if the service remains inequitable. Those six months proved to be very stressful and busy as the group attempted to carry out their work and run the political campaign, which was extremely difficult for all concerned. This did, however, have the effect of bringing members of the group together.

The great divide (them and us)

One of the consequences of running a service that is undergoing change is that resistance to change is inevitable. There is evidence that amongst staff in the maternity service, there is both a force that drives change that is met by an equal force that drives to maintain the 'status quo'. A state of imbalance creates an uncomfortable feeling for staff. In analysing the causes of resistance, very often the root of the problem is communication accompanied by misperception of the total situation (Brill, 1998). Another valuable concept that needs to be kept in focus is that:

> "it is important to recognise that a team does not exist in isolation, it is perceived by other people, each of whom will have their own perception of how the team operates. Most of this is perceived through the team's behaviour when interacting with others" (Dickson, 1998, p.14).

It is this difference of perception that has fuelled resistance to change. Management and Midwifery Supervision at the local Trust has taken the 'them' and 'us' divide very

seriously and attempts have been made to minimise this effect. Support and communication forums are available to all staff in the service.

The view of hospital midwives

When the project to establish the two MGPs was set up, most staff were very enthusiastic about embracing the new working patterns. There were no problems recruiting for the project. There were plenty of volunteers. Once the MGPs were established the climate changed and resistance became manifest. The first comments expressing resistance emerged when management established that hospital midwives would have to undertake some of the care of the women belonging to the Abbey MGP (as demonstrated above). This measure was not accepted by the hospital midwives. They compared the two MGPs and constantly lament the fact that they have to do Abbey's work.

Another problem the author has identified is that hospital midwives only notice the MGP midwives when they are in the hospital. This is only a very small proportion of their time. This promotes two types of comment from the hospital midwives: that MGP midwives do not work very hard or not as long and hard as the hospital midwives, or, when the MGP midwives are caring for a labouring woman (for perhaps twelve to fourteen hours), the hospital midwives state that they cannot possibly manage to work such long hours. In spite of many meetings with all staff where MGP midwives have spoken very openly about their satisfaction in working in the MGPs, the perception has not changed. Hospital midwives do not seem able to perceive the complete picture.

Another manifestation of resistance is the attempt of ward staff to exert authority over ward bed occupation. When an MGP midwife wards a lady, she needs to ask the ward

staff which bed the patient has been allocated. MGP midwives will often ask for one of the side rooms, so that they can provide the best available accommodation for their ladies. Ward staff will often block these beds in order to frustrate the MGP midwives. Some of the comments are:

> *"They* [MGP midwives] *think that their women are something special. I always tell them the rooms are not available."*
> (From field notes, hospital midwife)

> *"I'm sorry, but I do feel that that all women should have the same - these rooms are for very deserving cases only."*
> (From field notes, hospital midwife)

There have been reports (anecdotal evidence) that when ladies belonging to the MGPs have requested assistance or information, hospital midwives respond:

> *"I will contact your midwife, as you do not belong to us."*
> (From field notes, hospital midwife)

This has been addressed by management, but there is anecdotal evidence that this practice continues. The author would argue that this form of discrimination forms part of the resistance undertaken by hospital staff. It may only resolve if all staff move to working in MGPs, though there is a possibility that this behaviour may persist between all MGPs and the remaining hospital 'core' staff. Hunter (2002) describes the work undertaken by midwives working in the hospital environment as a 'with institution model' that focuses on universal, equitable care to groups of women as described in Chapter 2, and this would certainly resonate with the comments above.

The view of the MGP midwives

The midwives working in the MGPs perceive the hospital midwives as being obstructive and uncooperative. The following comments illustrate their feelings:

"They call me, I respond. They call me again, they have no idea that I am out in the patch and that it will take time for me to get to the unit."
(From field notes, Abbey midwife)

"They are seldom helpful. I have been working all day and I am on call so I respond to their call, I ask if they can admit my lady whilst I have my tea but they always seem to be very busy."
(From field notes, Abbey midwife)

"I want the best for my ladies, of course I do, so I will always ask if there is a side room available. I am cross when they just say no and the rooms remain empty."
(From field notes, Abbey midwife)

The MGP midwives comment that they are frequently called to care for one of their women and, if complications arise, they may need assistance. The labour ward may be very quiet and the hospital staff not busy; in reality they are socialising, but they do not volunteer to help their colleagues in the MGP, in actual fact there have been reports that the MGP midwives have to call upon their colleagues in the MGP to assist. This frustrates and infuriates the MGP midwives:

"I was so busy and that lot out there were chatting with nothing to do. You would have thought they could help."
(From field notes, Abbey midwife)

"I was desperately tired, had been on duty for so long and they would not help me to finish and ward my lady. I don't understand, we used to help each other out all the time in the past."
(From field notes, Abbey midwife)

Relating to this issue, the hospital staff have an alternative perspective:

"They [MGP midwives] *use the room and then just leave it expecting us to clean it out. They should do their own rooms. Total care means they have to do everything."*
(From field notes, Hospital Nursing Auxiliary)

This behaviour has developed as resistance to change, but also due to the fact that midwifery has for many years worked in hierarchical and controlling relationships (Page, 1995) and may also be a manifestation of the endemic 'horizontal violence'

described by Kirkham (1999). This could possibly have been avoided, or at least minimised, if the maternity service had been allowed to convert to MGPs as originally intended. Campbell and Bailey (1995) comment that when resistance to change is manifest, it motivates the different groups to be determined to perceive the change from their own individual perspective and omit focusing on the need for change.

> "Challenging people's opinions and values is not easy and is fraught with problems. Groups need to examine what they do and why they do it. This can be extremely painful and stressful" (Campbell & Bailey, 1995, p.156).

There is a desperate need to move the political agenda forward, in order that the changes to the maternity services may be completed so that staff have an opportunity to challenge the resistance to change. The management of the maternity service and the Trust are constantly frustrated by the obstacles and slow moving political agenda for change.

Group relationships

The Abbey MGP as a team is continuously evolving. During the timeframe of this study, the author has observed and reported some of the changes. They have survived the alteration to the group and have come to realise that new members can contribute towards a positive outcome for the group. Therefore, it is evident that change and development are ongoing. Morgan states that:

> "successful teams can only be created if development is continuous. Team development should be an integral part of the team's everyday work" (1997, p.51).

The term 'development' is defined in *Chamber's Dictionary* (Kirkpatrick, 1983, p.340) as "to bring out what is latent or potential, to bring to an advanced or more highly organised state". To this effect, the Abbey MGP meets once a month for their team

meeting. These meetings are a forum for communication from management to the group, the individual group members with each other and from the group to management. There is time allocated at these meetings for peer review sessions. These consist of reviewing a case that one of the members of the group has been involved in and, within the confidentiality and security of the group, the analysis is undertaken and conclusions drawn. This offers the group members the opportunity for debriefing and learning from each other, and develops reflective practice. It also serves to generate new ideas for practice. The meetings offer the opportunity for members to 'touch base' with each other. This is an informal process, but very valuable as it grants individuals the chance to connect with one another, allowing relationships to prosper. There is time set aside at the beginning and end of the formal part of the meeting when members converse with each other about any subject that is relevant. This could be work related or social, but both are valuable in supporting relationships.

As in most groups, the Abbey members have subdivided into smaller groups. The natural first group is the working pairs (four pairs in the group). The next grouping is the north and south pairs (two pairs). Thus, an individual member belongs to three groups. Subgroups are usually based on friendship or professional affinity. The relationships established can, in fact, contribute positively to the group experience (Brill, 1998). They provide a forum for deeper relationships that will allow the individual a safe environment in which to express feelings and emotions. Though the contribution of these subgroups may be very positive for all members of the group, they do bear an inherent danger of splintering the cohesiveness of the group if relationships break up.

During the interviews, members of the Abbey MGP remarked on the difference between work relationships whilst working in hospital and in the group. In the hospital environment, each midwife had to relate to many work colleagues. In order to maintain professional expertise in all aspects of hospital work, all staff are moved every six months to work in different areas (antenatal/postnatal wards, labour suite, antenatal clinic, community). This frequent move of personnel hinders the establishment of close working relationships that encompass a social element to them. The following comments gained at interview illustrate the point:

> *"When you work in hospital, you know everyone but not very well."*
>
> (Abbey midwife)

> *"Working with so many people you get to know who you can trust and who to avoid, but sometimes you learn by your mistakes; that can hurt."*
>
> (Abbey midwife)

> *"I knew everyone but I would not go out with them socially. Now that I work in the group I go out very frequently with my partner and also other members of the group. The whole group meets not only for work purposes but socially too, this is very important to all of us."*
>
> (Abbey midwife)

> *"It's so nice to get that feeling of belonging to the group. I feel I can tell my working partner everything and therefore I do not feel that I have to make decisions on my own."*
>
> (Abbey midwife)

It seems then, that the individuals are describing a more intense, personal relationship with their colleagues. This seems to create the support system required to ensure both the group and the individual are able to function not only on a day-to-day basis but, more importantly, when there is a stressful situation to confront. It is this element of support that individuals appreciate. The following comments portray this:

> *"When I worked in hospital and had to care for a stillbirth everyone was very sympathetic but did not get close. Now my*

partner is usually with me in the experience and we can talk as much as I need about it without feeling bad about it because I do the same for her."
(Abbey midwife)

"It was my first termination and I could not handle it. Nobody knew how I felt. That is what I thought, but my partner took me out and she made me talk. I talked and cried but felt so much better. This does not happen in hospital, I don't want to go back to that."
(Abbey midwife)

"When my child was sick, everyone changed their duties and on calls so that I could be with her. I did not have to ask, it was just done. It's great, we all support each other. It's good."
(Abbey midwife)

These relationships have built over time because the same individuals continue to work together. The close relationship established between members of the group ensures that everyone is sensitive to individual needs and support is provided. This is provided for personal and professional problems or dilemmas. The author argues that this more personal and intense relationship provides the nurturing of each individual that ultimately safeguards against stress and burnout, as evidenced in Sandall's (1997) work. This support grants an individual the opportunity to focus on the areas that are generating stress, whilst maintaining other priorities.

As time goes by, the relationships between the individual members of the group have continued to develop. These individuals know each other very well. This has some advantages, as discussed above and has allowed for the development of acceptance of individuality. During the first year of this study, most of the members of the group mentioned at interview that they (the group) had progressed to accepting each other. This is illustrated by the following comments:

"I now realise that they can accept me even with my own irritating ways and foibles."
(Abbey midwife)

"We are now more aware of how each of us 'ticks'."
(Abbey midwife)

"We are learning how to accept each other, warts and all."
(Abbey midwife)

These midwives have developed the ability to accept one another as individual practitioners with distinct personal and professional philosophies. They are comfortable with the concept that total agreement is no longer a pre-requisite for decisions, but the democratic majority rules. During the final year of the study, the interview and field data have established that this very close and intense relationship can have detrimental consequences. Familiarity has developed in the relationships, granting the individuals the right to become critical of their colleagues. This can put a strain on relationships. The maturity of the individual member is demonstrated by their ability to constantly guard against this process. Some individuals have used the opportunity of new members joining the group to change partnerships. This seems a safe mechanism that helps to preserve the group's integrity. The following notes are derived from observation field notes:

I note that [A] *is feeling very uncomfortable with the way* [B] *handled the delivery. There is strong criticism. Professional philosophies are very different and at times cannot be accommodated. The relationship has 'cooled'.*
(field notes)

[A] *and* [B] *have become very critical of each other. They have not voiced these criticisms at team meetings, but both have taken some individuals into their confidence. There is no evidence yet that all members of the group are aware of this situation.*
(field notes)

The situation between [A] *and* [B] *is now involving other members of the group that have been taken into confidence by both parties. There is a risk that the group may divide with different individuals taking sides. There is tension, but the subject is never mentioned in team meetings, yet I get the impression everyone knows.*
(field notes)

Now that new members have joined, [A] *and* [B] *have moved to partner the new members. The situation that threatened the group has now been resolved.*

(field notes)

This is an issue that the group needs to confront and acknowledge, so that strategies for coping with these circumstances can be put in place in order to safeguard the integrity of the group. Good communication is paramount in ensuring that the group continues to function, providing personal and professional development to its members. Brill advises the:

> "establishment of an open communication network within the team is one of the first and often, most difficult tasks. A climate of openness and honesty where people can speak freely, willingness to ask for clarification and use of feedback, and awareness that this will be an ongoing task throughout the life cycle of the team will do much to pave the way for better understanding and operation" (1998, p.200).

The argument here is that the Abbey MGP midwives need to become aware of the ongoing nature of developing an open communication strategy.

Social relationships

As mentioned above, each individual member of the Abbey MGP belongs not only to the MGP but also two other subgroups. The informal social meetings are most frequent for the partnerships. These midwives meet frequently in venues away from the workplace (individual homes, pubs). They discuss their work and agree professional strategies, reflect on practice and support each other. There are times when they also discuss personal problems. They also share humour that is so beneficial in developing relationships. The following comments depict this process:

> *"I like meeting* [C] *away from work. You can talk more freely, there are only the two of us so I feel safe. I can really say what I feel. She understands me so well. We also share the same interests away from work so we can chat about those."*
> (Abbey midwife)

> *"I love the fact that working in the group gives me such an opportunity to really get to know* [D]. *I now know most things about her. We have such a lot in common. I not only have a working partner but I feel I have a friend also."*
> (Abbey midwife)

> *"Going to the pub for lunch with* [E] *has an air of playing truant. It adds an element of fun to the work day. We can really chat and discuss anything, not only work, yet in a funny way it is all about work."*
> (Abbey midwife)

The last comment illustrates very well the importance of this social interaction. It may not all be strictly related to work in the strict sense of the word, but the building and strengthening of relationships is very much about work. The element of fun adds a healthy dimension to the work day and energises the individual emotionally, thus safeguarding against burnout. The social activities involve different members of the groups and there are times when all the group are invited to participate and occasions when the Abbey members meet and bring their families.

Applying Tuckman's (1965) model of group development, the Abbey MGP members seem to have achieved the third stage known as 'norming'. This stage is described by Tuckman as having the characteristics that:

> "...team members find a common working method. They are able to reconcile their own opinions with the greater need of the team" (1965, p.84).

Blair comments that:

> "Since a new spirit of co-operation is evident, every member begins to feel secure in expressing their own viewpoints and these are discussed openly with the whole group. The most significant improvement is that people start to listen to each other" (2000, p.9).

The evidence suggests that the Abbey midwives have given their overwhelming support to the concept of working in an MGP, where working relationships are long-term and have the opportunity to develop. Though there is a risk of a detrimental element to these relationships, the benefits far outweigh this small risk.

Final developmental stage

This is almost journey's end for the midwives moving along a spectrum away from a 'with organisation' model towards a 'with woman' model of midwifery, or at least as far as they can go without becoming independent of the NHS at this point. Tuckman describes the final stage of his model of group development as 'performing'.

> "The emphasis is now to achieve team goals. Relationships are settled and loyalty develops. The team is able to manage complex tasks and manage change" (1965, p.84).

This is seen as the culmination of group effort. The Abbey MGP midwives have demonstrated the progression through the continuum of the model of group development, and continue to do so.

Thus, Chapters 6 and 7 describe the developmental and transformational journey that the Abbey midwives have embarked on. At the beginning of Chapter 6 they were focused on their own problems and boundaries, but by the middle of Chapter 7 we are able to see that their focus has changed, resting now on the relationships with the women in their care, and it is from the base provided by these relationships that they have been able to transform themselves into dynamic, assertive and confident

practitioners. We have also been able to observe that, at the same time, much more personal and intense relationships have developed between the team midwives themselves, sometimes presenting them with difficulties which they have had to manage within the team, but also providing them with opportunities to exercise new skills necessary for sustaining this way of working. In the next chapter, the author will be analysing the impact that the new way of working has on the Abbey midwives' professional development.

Chapter 8

The Changing Dynamics of the Midwife-woman Relationship

The midwives' self-analysis

During the process of data analysis, a theme was identified which has been described as professional development. During the regular interviews throughout the period of data collection, rich data was rendered. As mentioned in Chapter 3, the Abbey midwives had a differing number of years' experience in different settings (hospital and community). During the analytical process, the author identified that the Abbey MGP midwives used a particular series of descriptive words to evaluate their professional development. During the interviews, some of the most frequently used were explored in more depth. Subsequently, analysis was able to draw these together under the theme of professional development, which in turn has been identified as a key aspect of the Abbey midwives' journey to a very different kind of existence from that which they described at the outset of the study. Needless to say, exploring these concepts within one theme in isolation can create false boundaries between them, when in practice most of these are interdependent and intertwined. However, for the purpose of clarifying just how the midwives' professional development was actually described by them, as a coherent element of the whole picture which this thesis attempts to create, it is a valuable practice to describe each element in some detail. During this discussion, Wenger's (1998) concept of 'communities of practice' proves particularly helpful in illuminating the midwives' progress towards a model of autonomous practice.

'Confident'

This was the word most frequently used by the members when attempting to evaluate personal professional development. *Chambers Dictionary* (Kirkpatrick, 1983, p.263)

defines confident as "trusting firmly, assured, bold". This suggests that they are trusting firmly in their professional knowledge, skills and understanding. The author noted that all the Abbey midwives referred to gaining confidence in the practice of their profession within the new framework, regardless of the years of experience. Providing a working environment in which each midwife is responsible for the total care of the women allocated, allows these midwives to:

> "...set themselves increasingly challenging outcomes, become more resilient in the pursuit of those outcomes and build an increasing belief in their abilities" (King, 1997, p.44).

The Abbey midwives have built an increasing belief in their abilities; this is not to say that they now 'know it all' but they are motivated to find out, investigate and research any perceived gap in their knowledge or experience.

> *Interesting to note some of the Abbey midwives make use of the Internet to research a topic. They subscribe personally to professional journals.*
>
> (field notes)

> *When a lady presents with a condition or complication in pregnancy, the Abbey midwife will investigate the subject in order that she can give sound advice to this lady.*
>
> (field notes)

Over the last six years these midwives have evolved from professionals who 'specialised' in some areas of practice[15] into confident midwives able to undertake the care of women throughout the entire pregnancy and postnatal period. This increased confidence in their abilities to practise has allowed them to question other colleagues' decisions, including medical staff. This has led to the occasional potential disagreement. A frank exchange of ideas usually resolves the conflict. The noticeable change is that these midwives now feel they are in a position to argue from a stance of equal power.

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[15] These midwives had experience in either the hospital or community settings. They are now experienced in both environments, offering a 'complete' service to the women in their care.

In the interest of providing the women with all the information available to make an 'informed choice', the Abbey midwives will research the subject and provide the women with information. They are very sensitive to each individual's desire and capacity to cope with the information, paying particular care to the volume of information given, as it can be overwhelming. The author would, however, argue that there is a risk that the information given may contain a bias towards a midwife's personal philosophy of practice. The author would recommend that this issue is addressed by management in a non-confrontational way, using education and professional development as a means to explore the influence of personal philosophies.

There is a case for further research to investigate whether growing confidence amongst midwives challenges medical dominance. It may well be the case that the ways in which midwives deploy their new found confidence and independence mimics the medical model, because the only experience these midwives have in using power is based on the current medical paternalistic model. The risk is that they adopt a paternalistic midwifery model that is characterised by the same attitudes displayed in the medical model. However, recent research carried out by Stevens (2003) and Pairman (2000) describes the development of a very close relationship between women and their midwives, that in turn generates a midwifery model of care based on a partnership between women and midwives (Gilliland and Pairman, 1995). These authors explain that this is a relationship of equals:

> "the midwife brings her knowledge, skills and experience and the woman brings her knowledge of herself and her family, her needs and wishes for the pregnancy" (p.4).

This close relationship and partnership will ensure that the midwives' focus remains centred on the woman. Davis-Floyd (1992) identifies the 'technocratic model' of birth

as the 'core paradigm' fundamental to contemporary obstetrics. This model focuses on the use of technology and invasive procedures that allow for the view of the woman's body as a defective machine that needs attention (from medics) in order to perform its function. Under this model, knowledge that allows for informed choices is vested in the technologies and those who know how to manipulate them. Midwifery, on the other hand, is firmly based on the holistic model that has at its hub the midwife-mother relationship (Jordan, 1993). Again, this echoes Hunter's (2002) findings of the 'with institution' model and the alternative 'with woman' model espoused by midwives working with a holistic approach.

'Knowledgeable'

As described in the previous section, these midwives are constantly seeking to increase their knowledge. They have gained knowledge on all aspects of pre-conceptional care, pregnancy, breast feeding and postnatal care. The following comments gained at interview illustrate this:

> *"I now know and understand about antenatal screening, all the tests available and can give good sound advice. That was an area I never felt very comfortable with before."*
> (Abbey midwife)

> *"It's so nice to have something unusual come up and go and find out all I can about it. To then share this information with the couple during the time of waiting. You have then done all the ground work and preparation before getting to labour. Particularly when you are preparing for a possibly damaged baby. These parents are able to cope better and you feel good about yourself."*
> (Abbey midwife)

The author has observed that working within the hospital environment means that individual midwives can abdicate responsibility for seeking knowledge as there are other colleagues and professionals at hand to provide the information required.

Arguably this also increases knowledge, but the author argues that this knowledge is very tailored to the specific problem encountered and it is her experience that very few practitioners in these circumstances obtain all the information available. The Abbey midwives are working in isolation from this institutional support and, in establishing the relationship with the woman or couple, they gain a responsibility that motivates them to find out as much as possible about the subject under discussion. Wenger (1998) comments that a group of individuals who share a common interest at work inevitably come together on a regular basis to help each other out, solve individual and joint problems, thus developing and sharing a common body of knowledge and a sense of identity. Wenger (1998) has denominated these groups as 'communities of practice'. This theory seems to develop the ideas of Brown and Duguid (1991) that, in the case of professions, the aim of learning is to become a practitioner and not to learn about practice. This, then, locates the development of a body of knowledge firmly in the communities in which knowledge is generated, developed and acquires significance.

As described in Chapter 7, the Abbey midwives meet on a regular basis to discuss work-related issues and set time aside to discuss professional dilemmas. It is in this environment that their personal and collective body of knowledge is developed within the community of practice, espoused by Lave and Wenger (1991). This acknowledges the value of the close relationship which these midwives have been able to develop with 'their women'. The work of Lave and Wenger (1991, p.49) is particularly helpful in understanding that "learning as increasing participation in communities of practice concerns the whole person acting in the world". The focus is on the ways in which learning is "an evolving, continuously renewed set of relations" (Lave and Wenger, 1991, p.50). In other words, this is a relational view of the person and learning. In the case of the Abbey midwives, the new set of relationships which are shaping the

community of practice within which they work are those relationships with the women they work with. It is reasonable to view the disparity between the views of the midwives working in the hospital and those of the Abbey team as being linked to the two distinctive communities of practice which have developed, and also as one of the unintended consequences of establishing the midwifery teams in the way in which they were constituted.

'Motivated'

In attempting to analyse this concept when used by the Abbey midwives to describe one aspect of their professional development, the author returns to the dictionary (Kirkpatrick, 1983, p.825) where 'motivated' is described as "an incitement of the will: a consideration or emotion that excites to action". In other words, these midwives now feel able to be proactive in their professional life in comparison to feeling they were reactive as in the past. Further research led the author to explore the concept of motivation from a psychology stance. She discovered that 'motivation' is an umbrella term in psychology covering wide-ranging concepts of attitude, belief, idealism, involvement, commitment, goals, expectations, aspirations, meaning and emotions. Engelbrecht (2006, p.46) states that the current interest in motivational concepts in work and organisational psychology lies in their ability to explain why people put effort and energy into the things they are engaged in.

The Abbey midwives expressed their perceived enhanced motivation to provide a holistic service rather than relying on others to offer information or input. At interview, the following comments illustrate this point:

> *"Thinking about it, I used to wait until I was faced with the situation and no-one else had sorted it out, then I would have to do it. I must confess, though, that if it was not urgent I too,*

would wait and hope someone else would do it. My excuse was that they were able to explain things better. I can't do this now, as I am the one that cares for this woman and she is looking to me for the answers."

(Abbey midwife)

"You gain a sense of responsibility for the women in your care and anticipate the problems so you get the answers, have them ready for her."

(Abbey midwife)

"[When] *one of the ladies I cared for had a breech presentation, the consultant told her that he would attempt to 'turn the baby'. This frightened her and when she told me I used the library and the Internet to get all the research available so that she could make her own mind up about having this done. I also gained from this, as I learned a lot about external cephalic version* [ECV], *useful for next time."*

(Abbey midwife)

As described above, motivation is gained not only from the different working environment that increases the sense of responsibility for the practitioner, but also by the relationship midwives are able to establish with the women. Additionally, their professional relationships with each other as members of a team, who can each act as an independent practitioner but also contribute support and understanding to each other, are described as quite different from those in the hospital. Extending Lave and Wenger's (1991) idea of a community of practice can demonstrate a sense of pride, for the Abbey midwives, in being able to offer a service which meets all the needs of their women, and thus supports those relationships and motivates the situated learning described above.

'Interested'

The dictionary (Kirkpatrick, 1983, p.656) explains this term as "a state of engaged attention and curiosity. Claim to participate or be concerned in some way". The Abbey midwives demonstrate this trend by feeling motivated to have an interest in the welfare of their women and are actively engaged in continuing this in order to achieve the best

possible outcome for them. These midwives are able to assess, plan, implement and evaluate individually-tailored professional interventions that they themselves have conceived. They express this in the following comment at interview:

> *"Mrs* [A] *developed gestational diabetes and I visited her antenatally more frequently to ensure that she was coping with all the information given. I made a point of accompanying her to see the consultants, so that I could talk with her from a position of knowledge and understanding. I researched the subject on the 'net' at home so that I was up to date with the latest thinking on the subject. I learned such a lot!"*
> (Abbey midwife)

This freedom to accompany the woman in all she faces, to investigate and update personal knowledge, is sparked by an interest in the woman and the circumstances she faces and, in turn, generates and sustains motivation.

'Committed'

Commitment is the kind of concept that most people understand but find it difficult to define. The author sought a dictionary (Kirkpatrick, 1983, p.86) definition, being "to do, to pledge, to involve". However, organisational commitment is described by Meyer and Allen (1997) as "a psychological state linking employees to their organisation". Commitment is regarded by most as a win-win situation for both the employer and the employee because, for the organisation, commitment may lead to better performance and lower absence, whilst for the employee commitment may lead to a feeling of identity within the group. The Abbey midwives expressed this concept at interview:

> *"Talking of commitment, yes I do feel committed to the group as a whole but I must say that my true feelings of commitment are to the women in my care. It is them that keep me going to work on the days I do not feel like working."*
> (Abbey midwife)

> *"Commitment... Yes, difficult to define... I feel that thinking about it, it is the feeling that I must not only not let my*

colleagues down but also I must not let the women down or even this great service we offer."
(Abbey midwife)

Thus, the Abbey midwives demonstrate that they feel a sense of commitment to the service, to each other, but above all, to the women in their care.

'Assertive'

This term is defined by the dictionary (Kirkpatrick, 1983) as "confirming confidently". In exploring the meaning of the term, the author came across the dictionary's (Kirkpatrick, 1983) explanation of the term 'assert oneself' as "to defend one's rights or opinions, sometimes with unnecessary zeal: to thrust oneself forward". Brill redefines the basic dictionary explanation of the term thus:

> "...in which people express their feeling and thinking in ways that show respect for the right to personal worth and to equal self-expression of those with whom they are interacting. This can be constructive to both participants" (1998, p.30).

Midwifery has a reputation of attracting assertive individuals to the profession, largely due to the historical struggle between midwives and the male-dominated medical establishment (Kitzinger, 1988, p.6). The midwives from the Abbey MGP grasped the opportunity to pioneer a new way of delivering maternity services to women. They were willing to leave a 'safe' and comfortable working environment to work in relative isolation and assume full personal responsibility for the care of their allocated women. All the midwives from Abbey MGP stated that the one quality they had noted had increased was, in fact, assertiveness. They express this in the following comments that are no more than a small sample of the data collected.

"The one thing I notice about me as a midwife is that now I am so much more assertive. I express myself better and I have the courage to say what I think."
(Abbey midwife)

"For me the thing that has changed the most is that I am far more assertive now. I get my voice heard. I can disagree with a doctor, but agree to disagree without feeling totally squashed as I used to before."

(Abbey midwife)

"I now inform the labour ward Sister or ask for advice. I am so much more assertive and I feel so much more comfortable with this 'new person' I have become."

(Abbey midwife)

Whilst analysing these concepts, the author has come to realise that in fact all these words used by the Abbey midwives are facets of the same quality: empowerment.

Empowerment

The term 'empowerment' has become a very popular buzzword. The dictionary (Kirkpatrick, 1983) only provides "to authorise" as a definition of this word and leaves the author dissatisfied. As described in Chapter 2, Page and Czuba (1999), however, describe empowerment as a process that challenges basic assumptions about power. In exploring the concept of empowerment, the author searched the literature and agrees with Page and Czuba (1999, p.5) when they state that "the meaning of empowerment is often assumed rather than explained or defined". These authors describe a process that can assist people to gain an element of control over their lives, as it fosters power to act on issues that are important to the individual.

This provides the author with a working definition of the concept of empowerment. In relating this definition to the Abbey midwives, their present working environment provides them with the opportunities to gain control over their own lives. They have no shifts to adhere rigidly to, dictated by someone else (management). They work in

response to work demands, thus exerting some control over their time. Some examples expressed at interviews are:

> *"It's so nice now. The only time I work afternoons, evenings and nights is when the group is short staffed or I am caring for a woman in labour. The majority of my time I work mornings only. I get to see the kids when they come home from school."*
> (Abbey midwife)

> *"I hate mornings. Having to get up so early for work was a real torment for me. I was frequently late. But now I manage my work late mornings, afternoons and evenings. I am only out if I am caring for a woman in labour or she is to have an elective caesarean section. I like it like this."*
> (Abbey midwife)

> *"When we first started I was very worried that I would end up seeing less of my daughter, but in fact this is not so. I am able to take her to school and then pick her up in the afternoon and if I am still working, I drop her off to the childminder. I am far more involved now than when I worked shifts."*
> (Abbey midwife)

> *"One of the nice things about working like this is that if one of us needs to change an on-call at short notice we can do it ourselves and only inform the labour ward who they need to call."*
> (Abbey midwife)

Empowerment provides the Abbey MGP midwives with the confidence to take some control over their work time. As discussed in Chapter 6, they also manipulate the allocation of the women they will care for. Their willingness for research to be carried out on their ways of working resonates with the empowered confidence described by Walsh (2004) in his study on free-standing birthing centres. The author, therefore, concludes that empowerment generates confidence, assertiveness, interest and motivation that emanate from a feeling of empowerment. However, in discussing empowerment we have to consider that the concept is based on the notion of power.

Power

Weber (1964) directs us to the concept that power exists within the context of a relationship. Page and Czuba argue that:

> "Power does not exist in isolation nor is it inherent in individuals. By implication, since power is created in relationships, power and power relationships can change. Empowerment as a process of change, then, becomes a meaningful concept" (1999, p.3).

This does not mean, however, that power is only seen in the context of 'taking power' from the powerful, but there is almost by definition a 'type' of power that actually strengthens the power of others. Kreisberg argues that:

> "power that is defined as 'the capacity to implement' is broad enough to allow power to mean domination, authority, influence, and shared power or 'power with'" (1992, p.57).

This is, then, the definition of power, 'the capacity to implement' that generates empowerment as a process within relationships. Midwives are proud of their title that means 'with woman' and the author argues that it is in that relationship 'with women', that power 'with' women generates empowerment for the midwives.

Changes to the woman-midwife relationship

Empowerment for the midwives has its roots in the woman-midwife relationship. Savage suggests that:

> "a link must be assumed between continuity of care and the nature of the patient-nurse relationship, care that is continuously planned and provided as far as possible by a single nurse is thought to allow the development of a 'close' relationship, and it is from this 'closeness' between nurse and patient that a therapeutic potential emerges" (1995, p.1).

She further defines 'closeness' as a form of rapport which allows self-disclosure or 'openness'. The relationship between midwife and woman is crucial to both parties. From the woman's perspective where closeness is allowed to develop, trust between the parties involved begins to grow and the woman feels able or empowered to participate in making decisions and choices for her pregnancy.

One of the benefits of working in an MGP is the freedom from adhering to shift patterns (Chapter 6). The midwives have an element of control over their working time, as they are available to work when required by their personal and group work, but are not required to 'cover' a hospital shift. When they have very busy times their visits to the women are only as long as required, but when time allows they have the opportunity to spend some time with their women and this allows for the development of a relationship built on trust and respect. The following comments highlight the high value the Abbey MGP midwives give to the relationship with their women.

> *"One of the things I really love about my job now, is that I know every one of the ladies allocated to me very well indeed, I know fairly well the ladies of my partner and I also know the ladies from the rest of the group. This means we can give them what they want or desire from the experience."*
> (Abbey midwife)

> *"I have the time to care. I mean really care for the ladies allocated. I know so much about them, they know a lot about me and we go almost beyond barely the professional relationship. I found this so when I heard one of the ladies explain to her toddler that she would be going to hospital for the birth of the new baby but this lady did not use the word ' hospital' she said ' the place where* [A] *works'. This made me feel so special. I now understand why our ladies are so much more relaxed, even in the hospital environment."*
> (Abbey midwife)

> *"One of the hardest things I face when working like this is saying goodbye to the ladies. It's not so bad if they plan more family, but I find it very difficult to say goodbye when I know I will not see them again. It takes me a while to get over it. Then I put my energies into the next relationship."*
> (Abbey midwife)

> *"When I was working in the hospital I used to think I had a relationship with every woman I cared for. I now realise that this is not so. You need time and frequent contact to build and maintain a relationship. In hospital you care for many women and the relationships are of necessity shallow and fleeting. They give you very little emotionally. Yet because I knew no different I was satisfied. Now if I had to return to that I just could not face it. It would remove the joy of my work for me."*
> (Abbey midwife)

Thus, the relationship needs time to develop and one of the key elements that nurtures this relationship between the woman and her midwife is trust. Griew (2003) states that:

> "Trust is highly significant. The woman learns to trust her body and the midwife to trust her own judgement, as well as to trust each other and the process of labour."

Kirkham expands this comment by saying that:

> "trust is infectious and the midwife's trust is conveyed to the woman. This is different from the self fulfilling prophesy of intervention 'just in case'" (2003, p.14).

Ball *et al.* (2002) highlight the importance that midwives give to this relationship. Their study identifies that one of the criteria for midwives leaving the profession is the inability to form and maintain close relationships with the women in their care. As illustrated above, this confirms the findings of this study. Guilliland (1995) comments that this relationship is based on a partnership that enriches both parties. Jamison (1994) however, states that this is impossible to achieve when the midwives themselves are disempowered. As seen above, the experiences of some of the Abbey midwives confirm that they are now able to establish and cultivate a trusting relationship with the women in their care, but would be unable to do so in the hospital work environment. This, again, fits into Hunter's (2002) two philosophically opposing models of midwifery care: 'with woman' as opposed to 'with institution'. It also resonates very clearly with Lave and Wenger's (1991) ideas around the development of communities of practice where

'situated learning', rather than being seen as 'internalisation' of behaviours witnessed, is characterised as essentially located in a network of social relationships and engaged in as a social activity with benefits for learners which are first and foremost experienced as enhancing social relationships.

Leaving the past

In the past, nursing training ensured that 'good nurses' had the ability to hide their emotions and therefore were detached from their patients. Menzies (1970) describes how nurses are controlled by the organisation of their work in order to safeguard them from emotional involvement with the patient. This culture of detachment from emotional commitment to the patient continues to permeate the NHS organisation. Because midwifery studies were often undertaken after completing nursing training, this culture has influenced the mother-midwife relationship within the hospital environment.

> "The organizational context of midwifery care has served to divert midwives from this fundamental relationship" (Kirkham, 2000, p.1).

The Abbey midwives are experiencing freedom from this influence and are able to become emotionally involved with their clientele. The following examples of comments given at interview by the Abbey midwives are:

> *"When you get to know a woman/couple, I mean, really get to know them, you inevitably become emotionally involved. It is part of the caring package. Isn't it??? Well... I prefer this way of working even if I have to face a bad outcome and the pain it can cause. I still would not change it."*
> (Abbey midwife)

> *"I know. I know!!! We are told not to get emotionally involved but if you 'care' then you inevitably are emotionally involved and I would say attached. It's what motivates me to give of the best, regardless of hours worked and outside commitments."*
> (Abbey midwife)

The author argues that this crucial element of involvement with their women allows the Abbey midwives to focus solely on the needs of their women and not the organisation (Exworthy, 1999; Kirkam, 2000). This adds further fuel to the 'them' and 'us' divide between the hospital midwives and the Abbey midwives. The author concurs with Hunter (2002) that the Abbey midwives are seen as 'deviant' from the main group. The author argues that her observations have led her to conclude that there is a fundamental jealousy of the Abbey midwives' ability, scope and freedom to work as the 'with woman' model described by Hunter (2002). This also causes problems for management, as the Abbey midwives are often perceived to be difficult because they will 'do their own thing'. One example of this change of focus is:

> *"I had a woman who had had a very disastrous experience last time. She was so very frightened and anxious. I felt I needed to be there for her and to visit every week even if only for a few moments. This gave her* [the woman] *the reassurance she needed and calmed her down. We managed to get through the pregnancy this way and to our joy the outcome was good. If I had adhered to the regular antenatal visit routine, this woman would have succumbed to anxiety and I do not know what the outcome would have been. But I got into trouble for doing too many antenatal visits. How can you not give the women what they need? I could not turn my back on her. I now see her about town with her baby and she looks radiant."*
>
> (Abbey midwife)

In contrast, here are the comments of a manager that illustrates the different agendas between the professional and managerial staff, as described by Exworthy (1999) in Chapter 5.

> *"We should aim at equity of service and these midwives provide a very good service but so much time and mileage is spent on all these 'extra' visits, the budget cannot cope with it. We do not have the resources to give this kind of luxury service."*
>
> (Hospital manager, from field notes after management meeting)

This change of focus has brought the Abbey midwives into conflict with management philosophy and resource allocation. The author argues that this is at the heart of the perception that the Abbey midwives are so difficult. The view that over commitment to one woman may divert attention from others, with the inherent danger of causing an unequal division of labour among staff (May, 1991), forms part of the current hospital culture.

Possible pitfalls

The freedom to relate to their women gave the Abbey midwives the opportunity of emotional engagement. But for some it meant changing, as described by Martschinke (1996), from emotional detachment to "learned control within a friendly relationship". The problem is that in the transition from the hospital environment to community work, the Abbey midwives have had no preparation nor educational support in understanding the development of a 'therapeutic relationship'. They have had to explore the emotional issues as individuals. Martschinke highlights this point by stating:

> "...the challenge is to find the appropriate mixture of personal involvement and professional emotional control that suit both the nurse and the patient" (1996, p.23).

The Abbey midwives found themselves not caring for a group of women in a hospital, but visiting individual women in their homes, where a one-to-one relationship is allowed to develop. Even when it also includes other members of the family, the focus remains on the midwife-mother relationship. Siddiqui describes this relationship thus:

> "The relationship that develops between the woman and the midwife is at the core of human caring and may provide the basis of the professional body of knowledge that encapsulates midwifery" (1999, p.111).

Page (1993) affirms that midwives develop a relationship with the women they care for based on sensitivity and trust. Deery and Corby (1996, p.251) explain this concept by stating that a therapeutic relationship is developed when each party is convinced that "the other is trustworthy, dependable, accepting, sensitive and consistent". Lawton (1987), however, comments that the profession seems to have 'neglected' to consider the consequences of the "amount of energy that that may be used when midwives use themselves as a therapeutic resource for women". Deery develops this further by arguing that:

> "this relationship also enables the practitioner to effectively plan care for clients in order to enhance the effectiveness of such care" (1999, p.252).

Deery (1999) advocates the use of clinical supervision to provide support for midwives faced with increasing emotional demands. However, developing clinical supervision will not only 'involve a cultural change' argues Deery (1999), but also a redefining of the role of the Supervisor of Midwives. The author explores this concept further and concludes that midwives are human and will bring to any relationship elements of their past (Briant and Freshwater, 1998). The elements of transference should be understood by midwives in order to develop a therapeutic relationship. Every human relationship is coloured by transference. All people project part of their personalities onto others. This is a two way process, as not only do we project, but we also receive some aspects of other people's personalities (Jacobs, 1986). The creation of a mutual alliance involves both parties accepting each other in their humanness. This is described by Briant and Freshwater as:

> "mutuality involves revealing humanness which is not something that comes easily. Nurses need to be helped to develop an awareness of their own vulnerability and also to discover what impact this has on the therapeutic alliance" (1998, p.211).

The author particularly likes the definition of a therapeutic relationship given by McCrea, as it comes with a midwifery perspective. This is:

> "In the midwifery context therapeutic relationship may be defined as 'being with women' and understanding them. It is a relationship that develops through several interactions between midwife and woman" (McCrea, 1993, p.48).

This study highlights the lack of understanding of a therapeutic relationship and inadequate support available to the Abbey midwives (Chapters 6, 7 and 8). The author suggests that local supervisors of midwives look to clinical supervision as a model to provide a supporting framework for midwives engaged in therapeutic relationships. The warning should be headed that:

> "exposing midwives to more intimate interactions with the women in their care can lead to emotional exhaustion and exposure to the dynamics of a relationship that midwives have not been adequately prepared for" (Deery, 1999, p.253).

The author argues that there is an educational need that has not been met by management for these midwives. Lawler identified this gap in learning thus:

> "The problem was that nurses were never educated about emotions, the expectation was that there was a job to do and the nurse just did it, independent of emotions" (1991, p.128).

This serves to demonstrate that organisational thinking has not changed over the years. As stated above, some of the Abbey midwives find it difficult to 'say goodbye' at the end of the postnatal visiting period, particularly when there has been a bad outcome. Conversely, some of the women, in their feedback letters, confirm the difficulty they also experience in coming to the end of the therapeutic relationship and saying goodbye to their midwife. The author thus concludes that this is the element that motivates both the women and midwives to manipulate the case allocation to ensure that the women are cared for by the same midwife in subsequent pregnancies.

Martschinke highlights another pitfall of emotional involvement when she states that:

> "Nurses are warned that becoming too involved with patients caused the patient to become dependent on a specific nurse and if that particular nurse was not on the ward the patient may not express their needs or concerns" (1996, p.23).

This, however, has not been the experience of the Abbey midwives. The women are able to relate to all midwives in the team, but have a close relationship with one or two of the team. The author would draw attention to the need for education and psychological support for the Abbey midwives in establishing and maintaining healthy 'therapeutic relationships' that allow for involvement, but also assist the practitioner in establishing the boundaries that ensure they are able to 'give' equally to all the women in their care. The author would argue that the Abbey midwives have formed their own informal community of practice, with its own rules, which provide support based on values congruent with the situation within which they find themselves. This example provides a valuable lesson as to the ways in which successful teams find ways to support those practices, in which they learn to value situations where emotional satisfaction is provided by the ability to do a 'good' job for clients.

Job satisfaction

It is the ability to establish and nurture a relationship with their women that provides the Abbey midwives with their motivation and job satisfaction. This is made clear in the following comments:

> Interviewer: "When you have worked all day and are up most of the night, what keeps you going?"
>
> *"I am there for the women I care for. She knows me and I like to be there for her. It's funny you know but I used to hate night duty with a vengeance, I felt so tired and physically sick, but now, I can be working all day and up most of the night and*

indeed sometimes all night but I feel fine, content and happy. Yes, tired but happy."

Interviewer: "Why happy?"

"Because I have been there from the beginning and I would not miss the delivery if I possibly can. It is the ability to do the complete job with most of the women that gives me such joy. I know them, they know me. It is great!"
(Abbey midwife)

Flint (1995) has suggested that a midwife delivering a woman she has cared for and known finds that the involvement in the relationship will carry her through the odd sleepless night; in the same way that being in love allows us to cope without sleep from time to time. Benner and Wrubel state that caring:

> "unleashes the possibilities that are inherent in the self so that the carer, as well as the cared for, is enriched in the process" (1988, p.32).

The two key elements that are necessary for the relationship between mother and midwife to develop are time and continuity of carer. Allen *et al.* (1997) reaffirm this concept, as do Stapleton *et al.* who declare that:

> "in the setting of continuity of carer, midwives can both give and facilitate better support for mothers. It is significant that in such settings midwives also build better support systems for themselves" (1998, p.236).

Kirkham (2000, p.237) comments that this support for mothers and colleagues is possible because "they [midwives] are outside, or sheltered from disempowering hierarchical pressures". Therefore, moving away from the direct influence of the hospital hierarchical structures allows midwives the freedom required to develop relationships with the mothers as well as their work colleagues. These findings confirm Hunter's (2002) work described in Chapter 6. The development of the mother-midwife relationship provides the midwife with a change of focus. The midwife's loyalty shifts from the employer and profession towards the women she cares for (her clients)

(Brodie, 1996a, 1996b; Hunter, 2002). This then can cause a sense of unease for the management team, further fuelling the 'them' and 'us' divide between Abbey and hospital midwives. This is highlighted in the following comments, gleaned from the author's field notes taken after spending time in the Labour Ward and also from conversing with an Abbey midwife:

> *"I am very concerned at the amount of epidurals that are used in the Unit, we hardly use any at all, and I think it's because we actually stay with our women in the room the whole time, they* [hospital midwives] *just pop in from time to time so if she [the woman] is having a hard time, or is making a noise, then the easy solution is to suggest an epidural. We hardly suggest the use of epidurals and use our presence, massage, encouragement, we live the experience with them and we come through together."*
>
> (Abbey midwife)

The view of the hospital midwives, however is very different:

> *"They* [Abbey midwives] *stay in their room with their women all the time, they don't mix with us. They think that they are so superior but after all we are all midwives and can do the job."*
>
> (field notes, hospital midwife)

> *"They* [Abbey midwives] *always want the best rooms/beds for 'their' ladies, I am fed up with them... they think the only clients are the women they care for. Who do they think they are? We have to care for all the women, not just a select few."*
>
> (field notes, hospital midwife)

> *"The Abbey midwives are so difficult to manage, they are out there on their own and I wonder just how much they adhere to all we expect of them. They always want to change things to fit in with a woman's request or expectations."*
>
> (field notes, manager)

By taking the opportunity to focus on their women and not the organisation, the Abbey midwives have a strong relationship that supports the mothers they care for, but also generates support for group members. This provides them with the deep feeling of job satisfaction that sustains them when sleep is scarce and times are hard and stressful.

When questioning the Abbey midwives on the subject of job satisfaction, one notable conversation was as follows:

> Interviewer: What gives you job satisfaction?
>
> *"Working with the women, I love getting to know them and to build a relationship with them."*
>
> Interviewer: So it is the relationship itself that is important to you. Why?
>
> *"Yes, hmmm, I find getting to know, you know, really know the women is important. I suppose it's because I need to be needed. Yes, it's that that fills the whole of job satisfaction."*
>
> Interviewer: But why do you need to fulfil the need to be needed?
>
> *"Hummmm. Difficult to put into words... but I suppose because it is that it gives me the motivation to do the very best I can. She* [the woman] *gives me that, you know, meets my needs and I then give her all I have. Yes, that is it, that is the best I can describe it as."*
>
> (Abbey midwife)

This study reveals that there is a conflict of focus between the Abbey midwives and the rest of the service. The author is of the opinion that the Abbey midwives' emphasis on focusing on the woman-midwife relationship has changed these midwives and their loyalty - towards being very much with the women they care for and collegial relationships. Professional concerns are now secondary in their order of priorities (Kirkham, 1999; Hunter, 2002). The women respond to this and, in Chapter 7, the author made reference to the way the midwives and women conspire to ensure that continuity of carer is achieved. The author thus argues that the profession of midwifery should consider whether the name 'midwife' meaning 'with woman' should be granted only to those working in continuity of carer systems, where they are truly 'with woman', and midwives working within the hospital hierarchical systems should devise a different title. Controversial as this concept may be, it would truly represent the condition of the profession at present.

Management should also consider this issue and perhaps learn to acknowledge these midwives' professional development and maturity by positively embracing the concepts of professional autonomy and accountability that are available in independent practice. As indicated in previous chapters, this serves as the model for implementing continuity of carer systems. Walsh (2007) describes how midwives working in a free-standing birthing centre were able to offer "care as a gift" to the women accessing their service. Walsh (2004) highlights that it is envisioned and motivational management that empowers midwives to practise in new ways. The move to continuity of care would not only recognise the professional development of the Abbey midwives, but would further develop the whole profession. After all, GPs and solicitors practise independently within professional guidelines and accountability, but without the hierarchical management structures that, by necessity, focus on employment (litigation) and professional issues, paying only scant attention to the women and their needs.

The author would argue that autonomy is only gained with a self-managed structure. Stock and Wraight (1993) highlight the fear expressed by managers of losing managerial control. Henderson (1997) and Kirkham (1999, 2000) emphasise that midwives working shifts fear the loss of their accustomed working patterns.

> "While continuing responsibility for the care of individual women can bring clear benefits for midwives in terms of autonomy, support and job satisfaction, it can also be experienced as a threat. Midwives contemplating such care from within existing systems fear sacrificing what they have within the *status quo*" (Kirkham, 2000, p.237).

It is perhaps an opportune moment in which to point out that the old fashioned rhetoric that midwifery is different from nursing and medicine because it is focused on 'wellness' and a holistic approach, is no longer relevant with the emergence of the

primary care philosophy based on these principles. Perhaps it is time to articulate that the unique nature of midwifery is based in the relationship between the midwife and the woman (Leap, 2000). Wilkins explores what makes the woman-midwife relationship 'special' for both parties. She defines the relationship thus:

> "The 'special relationship' of which so many women speak is a personal one in which they are emotionally engaged and each party becomes known to the other, placing the other within a personal and biographical, rather that a narrowly professional context. This in turn requires continuity of career" (2000, p.29).

Thus, the Abbey midwives are uniquely placed to engage in this 'special relationship' with the women they care for and this, in turn, provides them with the job satisfaction that motivates them to develop. As pertinently demonstrated in this study, the Abbey midwives have undergone a transformation. When they first set out along this journey of self-discovery they were focused on matters personal, matters organisational and matters of professional boundaries. Now, however, they are totally focused on the relationships with the women in their care. It is these relationships that validate them as midwives and, in turn, have influenced their relationships with their colleagues.

Changes to midwife-doctor relationships

Authors such as Turner (1987), Donnison (1988) and Tew (1990) have compiled a detailed historical development of the midwife-doctor relationship. These authors illustrate the development of this relationship and the power balance that continuously struggles to find definition between the two professions. The origins of contemporary modern occupations such as nursing, midwifery, physiotherapy and social work are embedded in the social, political and economic changes of the nineteenth century (Corrigan and Corrigan, 1979). These professions provided work outside the home for

women, although, as stated by Walton (1975) and Hearn (1982), they were and continue to be shaped by the patriarchal structures from which they developed.

According to Turner (1987), hospitals are essential institutions within modern healthcare. They are symbolic of the social power of the medical profession and they represent the institutionalisation of specialised medical knowledge. The emergence of the feminist movement provides a critical voice against the patriarchal attitudes still present in medicine. This power base, centralised in hospitals, has generated the political reforms that moved birthing away from the home and into the hospital, under the direct influence of the doctor. Donnison states that:

> "...although in Britain the midwife is the most senior person present at 76% of all deliveries, she has in many cases, especially in consultant units, declined to little more than a handmaiden of the obstetrician and a minder of his machines" (1988, p.203).

For the Abbey midwives, the move (physical) to the community and a small Birthing Centre, away from the main hospital, has proved to be a crucial element in their professional development. They have moved away from the direct influence of the obstetricians. Once they adjusted to this new concept, they ceased to view pregnancy from the medical stance and regained the confidence in their own expertise. The boundaries between normal pregnancy (which is the domain of the midwife) and complications (which come under the jurisdiction of the obstetrician) are more clearly defined for the Abbey midwives. This different perspective is yet another element in the 'them' and 'us' argument between the hospital and the Abbey midwives.

Donnison (1988, p.206) draws attention to the current view held by most medical and midwifery hospital staff, that defines a midwife as "a professional member of the obstetric team". This definition fails to acknowledge the midwife's status enshrined in

statute as an independent practitioner. Donnison (1988) also highlights the dilemma faced by midwives wishing to exercise their professional judgement and who dare to deviate from rigid medical protocols and guidelines as they often face, however successful the outcome, serious harassment from the hierarchical medical attitudes of their managers who are more concerned with litigation than developing midwives' clinical expertise. This is confirmed by Exworthy and Halford (1999), who describe the often conflicting agendas of professionals and management. This is the experience of the Abbey midwives and the following are some of the comments received during interviews that illustrate this point:

> *"Now that I have been out in the patch and have gained confidence in the birthing process and a woman's ability to birth I no longer feel so comfortable in the hospital environment. It makes me feel that 'they'* [the senior midwives and doctors] *are just waiting for the opportunity to intervene. I know that I should tell the shift co-ordinator what is happening all the time, but they then take over and intervention follows, so I just leave it until I think intervention is required before I tell them."*
>
> (Abbey midwife)

> *"I just don't know who they* [Abbey midwives] *think they are. They take the woman into the room and then they closet themselves in there. They never tell you what is going on, but as senior person I am responsible and often have to pick up the pieces when things go wrong."*
>
> (hospital midwife)

> *"The thing that upsets me most is that there is an attitude of disapproval but they* [hospital midwives] *fail to see us at home births where the atmosphere is so much more relaxed and better. We now take this with us to the hospital and work from the premise that all is normal until... but they* [hospital midwives] *work from the opposite point of view, very much along medical lines. We then get into trouble because we have not used continuous cardiotocograph or some such guideline and are accused of not caring for our women. We in effect care more because we know them. And it will be us that visit postnatally and face the questions from the parents. I no longer like to work in hospital and, sad to say, I no longer like some of my colleagues on a professional stance."*
>
> (Abbey midwife)

There is a satellite Consultant Antenatal Clinic run in the Birthing Centre in the Abbey midwives'[16] patch. This provides the Abbey midwives the opportunity to be present with the consultant when the women are seen. They are able to discuss the plan of care for their women, involving both the woman and the consultant in the planning. This has meant that the consultant has got to know the Abbey midwives and they now discuss the care of 'their' women with him. This often takes place in the main unit as an opportunistic encounter, or by seeking to speak to the consultant at the end of a clinic in the main unit. The author has observed that the manner of speech between these two professionals is still deferential, but more informal and relaxed.

> *The midwives converse with doctors (Registrar, GPs) and consultants on a more commensurate manner. They will now dare to disagree and offer alternatives based on sound knowledge and reference with current research findings. The Abbey midwives are a considerable force and power is more equal in these exchanges. Some doctors however, do not feel comfortable with this and attempt to regain power by dictating the way forward. The midwives can now agree to disagree with them.*
>
> (field notes)

This in turn has led to the Abbey midwives feeling empowered to refer directly to the registrar on duty when a referral in labour is required, often bypassing the Senior House Officer (SHO) and even the senior midwife in charge of the shift. She will be informed once decisions are made as a matter of courtesy. This, once more, demonstrates that the Abbey midwives place their loyalties with the women in their care and not the organisation and the hierarchical structures therein. Unfortunately, this has fuelled the 'them' and 'us' argument. This also has implications for the training and development of SHOs and is an issue to be considered when all teams are out. The following comment gained at interview highlights the Abbey midwives' stance:

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[16] At the time of writing this study, this service has been withdrawn by the local Trust. However, the Abbey midwives have transferred this new way of relating to senior medical colleagues to all local consultant obstetricians.

> *"Having discussed her care* [the woman's] *with the consultant I already know where we are to go. I now do not need to refer to the SHO. I go straight to the Reg.* [Registrar]. *I now find I do this even when the first opinion of the consultant has not happened. I just feel they* [SHOs] *are not as experienced as we are and will only refer to the Reg anyway with their version of events, so I do it myself direct to ensure all facts are passed on with no other interpretation but my own. This makes me feel that I am able to give the best possible care to my lady."*
>
> (Abbey midwife)

There has also been a change in the way the Abbey midwives communicate with GPs. When the Abbey midwives first started out in the team, they were faced with the fact that, in most antenatal clinics in GP surgeries, their role was as a handmaiden to the GP. Over time this has now evolved into midwives' antenatal clinics and the women share care with the GPs on alternate visits. This is evolving further, as the women realise that they have the midwife's undivided attention and antenatal visits can be arranged at more convenient times. Most women are opting for midwife only care. The woman's GP is kept informed as a matter of courtesy. The otherwise heavy demands on the GP's time and the increased awareness of the consumer who is exercising her choice has led to no more than a comment, so far. The following comment from an Abbey midwife made at interview illustrates this point:

> *"It's funny really, how the women are voting with their feet and now they know we are here and what we do and how we can fit in with them they prefer our service to going to the GP and waiting in the surgery worrying about picking up kids from school."*
>
> (Abbey midwife)

This demonstrates how the power balance between the professions has changed and continues to change.

Changing relationships with managers

Mills (1956) has analysed the tendency of professions to segment and the way power is then located within a managerial sector of the profession. Within the caring professions (which include nursing and midwifery), there has been a select group of practitioners who have elected to move into the management structure. They, in turn, are supported by administrative personnel. This has then left the practitioners occupying a low hierarchical position. Within the hospital structure it is the management that makes the decisions, and aims to 'control' the practitioner. During the 1980s there was a further move to reduce the decision-making power of nursing and midwifery practitioners by introducing the principle of general managers, who had no connection to the profession managed. General management creates a schism between the Chief Executive with the overall view and the sectional managers who possess the overview of their section, leaving the practitioners with no overview but focused on, in the case of midwifery, the woman (Hugman, 1991).

Working within the hospital environment exposes the Abbey midwives to the hierarchical power structures that operate there. According to Hugman (1991, p.64), the actions of both managers and workers are "affected by other institutional forces such as education, religion, race, gender and the family". He also argues that the practitioner may gain knowledge and skills beyond those of the manager, and therefore need to be allowed a degree of freedom. This has the effect of limiting the power of the manager, who becomes dependent on the practitioner's knowledge. The practitioner then gains a degree of power that will allow her/him to influence practice (Hugman, 1991). This point is demonstrated when the Abbey midwives co-operate with the women to 'bend' the rules, so that the women can be cared for by the group (as described in Chapters 6 and 7 of this study). However, relationships are always influenced by gender.

Gender

The issues of power, empowerment and relationships cannot be discussed in isolation from the gender issue, as this influences all of the above. Gender issues in these discussions do not curtail themselves to the distinction between femaleness and maleness but, as described by Oakley (1974) and Game and Pringle (1983), they also refer to the social and cultural constructions that ascribe femininity and masculinity to organisations and the relationships therein. Gamarnikow (1978) argues that nursing (in hospitals) represents a clear example of the professionalisation of women's domestic roles. He describes nurses as the 'housewives' of medicine. The matron in Victorian times had authority over the 'domestic' nurses, but was subject to the authority of the doctors.

The social acceptance that caring professions are basically women's work has had the effect of legitimising their lower status. The caring services, of which midwifery is a part, replicates the patriarchal relationship of women serving men, midwives serving doctors. The comparatively low salaries (caring is done for love, not money) and the perceived need for managerial control that is regarded as natural and necessary are the product of the position of women within patriarchy and not from the intrinsic value of the work they do (Hugman, 1991).

Hearn (1982, 1987) argues that the process of professionalisation is itself patriarchal, in which men have appropriated control over all areas of social and domestic life in Western culture. Thus, the issue of gender is closely linked to the distribution of power and control that influences all aspects of midwifery work. Midwives may be mostly women, working with women and managed by women, but nonetheless constrained by

the pervading patriarchal culture of the NHS. Whilst working in this environment, the Abbey midwives have managed to work across the hospital/community interface, developing into a 'new' midwife.

The 'new' midwife

The Abbey midwives have evolved over the years, changing professionally. They have developed into confident, knowledgeable, assertive, empowered, interested and motivated practitioners. Their focus for motivation is no longer the organisation, but the relationships with the women under their care. This has led to a constant challenge and overt ways of redressing the power balance.

Management does not find them an easy group to 'manage', but the profession gains from this power shift as it challenges practitioners to contemplate the state of midwifery and its role within healthcare. The author is of the opinion that perhaps consideration should be given to changing the power and control of management for an autonomous practitioner who is totally accountable. The guidelines and work philosophies should be individual and encourage independent decision-making. This should have an inherent acceptance of risk and the uncertainty of clinical practice. This could be achieved and supported by ongoing professional education and enlightened and envisioned supervision, with the acceptance that midwives working in MGPs are autonomous practitioners. However, the reality is more likely to be as highlighted by Hugman:

> "The future will be one of continued struggles around the relationship between professionalism and hierarchical managed employment" (1991, p.81).

The author is still hopeful that the struggle will not be in vain and that these midwives will, one day, gain the recognition they deserve.

Conclusion

The Abbey midwives have undergone a great deal of change in their relationships. For them, this has been a transformational journey. This study follows their transformation. The author has described the journey from the beginning, when these midwives were focused on the immediate 'things' that affected then or were perceived to affect them. These midwives were inward looking and busy establishing a working relationship with each other. As described in Chapter 2, the author highlights the work of Menzies (1975), who undertook a study that described the organisational stance, that therapeutic relationships with patients created high levels of tension, distress and anxiety among nurses, and the organisational response was to use a task-orientated approach that ensured nurses were 'safeguarded' from the perceived anxiety of relationships. The Abbey midwives, however, along this transformational journey, have managed to change their focus from inward looking to a relationship developed with the women in their care. At the very core of their 'raison d'etre' is the relationship they are able to establish and maintain with the women. As described in these chapters, it is this relationship that motivates, empowers, gives confidence and spurs these midwives to maintain (and manipulate to maintain) some control over their working environment. This, in turn, protects them from the effects of burnout, as evidenced in the work by Sandall (1997).

Freudenberger (1974) is commonly considered to be the first to identify and use the term 'burnout' to describe the experience of emotional depletion and loss of motivation and commitment. Both Schaufeli and Enzmann (1998) and Maslach *et al.* (2001) have contributed qualitative research into burnout. The quantitative research work undertaken by Maslach and Jackson (1982) describes the Maslach Burnout Inventory that has

subsequently become the predominant Burnout Measuring Instrument (BMI). This was the first to measure burnout in healthcare/social care settings.

In midwifery, there are two major contributions to the research on burnout. Bakker *et al.* (1996) attempted to consider if a correlation between burnout in Dutch community midwives could be explained in terms of workload and work capacity. They found that some results were surprising. For example, the more hours a midwife worked per week, the higher was the sense of personal accomplishment. Another example is that a higher rate of home births leads to less emotional exhaustion and less depersonalisation, therefore, deliveries undertaken in the home, as opposed to the hospital, reduced the risk of burnout for these midwives (Bakker, 1996, p.180).

Sandall (1997) undertook a British study of the impact of continuity of care on midwives' burnout. The data was generated from three very different sites, varying from total one-to-one continuity of care to care within a team. Sandall (1997) found that control over their personal work organisation, and social support (both at work and at home) combined with the opportunity to develop meaningful relationships with the women was, in fact, associated with a reduced risk of burnout. Walsh (2004) has also described the importance of the blurring of the work-life boundary and the ways in which relationships between the midwives themselves and each other's families can be experienced as a source of emotional and practical strength.

As described in this study in Chapters 6, 7 and 8, the Abbey midwives have developed a working environment and community of practice that protects them from the effects of burnout. They are able to establish and maintain meaningful relationships with the women in their care, and an example of this is the need from both the women and the

midwives to re-establish the relationship at a subsequent pregnancy. This is also reflected in the conspiracy that generates the alliance of the women and the Abbey midwives to defy management's ruling and avail themselves of continuity of care regardless of geographical boundaries (Chapter 6). These midwives are supportive of each other, and this study demonstrates that they are able to exert control over their personal work organisation. Thus, they are protected form the phenomena described as burnout.

This study clearly illustrates the transformation of these midwives. The language they use to describe elements of their professional persona demonstrates the growing confidence in their abilities and decisions as midwives, and we see here, without a doubt, the fact that the Abbey midwives have moved to the truly 'with woman' model described by Hunter (2002) in this, their transformational journey. In the following chapter, the author describes the impact that working in the MGP has had on the Abbey midwives' personal/home lives.

Chapter 9

The Abbey Midwives' Personal Development

In the beginning

When first setting out to work in this new way, the Abbey MGP was made up of individuals from both the community and hospital settings who had addresses in the patch to ensure safe cover for on-call hours. These individuals have had to learn to work together. As described in Chapters 6 and 7, the original group has experienced many changes; some midwives have left and others have joined the group. In setting out to analyse the influence the new way of working has had on the individual midwife, the author has discovered that much of what has been teased out in the analytical process to fit into other themes (already described) does in fact 'spill' over into the personal lives of the individual midwife. This is because the lines of demarcation for the analytical themes are, in fact, constructs which, to some extent, have been imposed on the data for the purposes of the researcher. In order to comply with the conventions of producing a written thesis which makes sense of a complex set of processes, the analysis necessarily moves some distance from the original experiences which are the topic of any research. Hopefully the analytical process, while losing some elements of the original situations, also adds something of value, which can aid understanding. Thus, the author presents the themes that the analysis has rendered and the starting point is the one issue that threatened the cohesion of the group at the very beginning.

Cars revisited

This theme looks at the impact working in the Abbey MGP has, or continues to have, on the individual midwife. One of the first issues highlighted by them, and one which had an impact on family life for these midwives, was the utilisation of lease cars for the ex-

community midwives but fleet cars for the ex-hospital midwives. This issue became a huge problem for the fledgling team to overcome, and though the issue has now ceased to be contentious, it has not disappeared altogether. This issue has been discussed in detail in Chapters 6 and 7 of this study. The author wishes to revisit this subject in order to focus on the reaction from the partners. It is interesting to note that the partners perceived the Trust's provision of a basic small car as insignificant recompense for the long hours worked.

> *"*[A] *works so hard and the hours are long but the Trust only gives them such a basic car, by the time all the equipment is in then it cannot be used for anything else."*
> (Abbey midwife partner)

> *"Yes, I often work long hours and I am often away from home, but I have a nice big comfortable family car for domestic use. Those cars are so small that it only serves for school runs or shopping."*
> (Abbey midwife partner)

> *"There is no status in those things* [cars]. *The girls should get more for their efforts and long hours."*
> (Abbey midwife partner)

Analysing the comments made by the partners seems to indicate a sense of prestige is required by the males to proclaim the 'worth' of their work. They seem to acknowledge the inconvenience their work may cause the family, but their justification is the provision of a large family car. The author finds these comments interesting in the light that observation has led to the realisation that, for most families that need a second car, a small basic model is often the one of choice for women to undertake the school run, shopping and get to work. Barthes says that:

> "The car is consumed in image if not in usage by the whole population... [it is] the exact equivalent of the great gothic cathedrals" (1972, p.169).

The author concludes that, for these partners, the value placed on the inconvenience to them (as they now need to take responsibility for sharing family duties and work) needs somehow to be recompensed in a car of a certain specification that will contribute to the family status, thus enhancing the family image to the rest of the population.

> "Car ownership in general or the ownership of particular models does or does not enhance people's status position. The car as a locus of consumption remains on the drive of the house" (Urry, 1999, p.6).

For the midwives, the fact that the Trust has the selection of the cars provided, eliminates personal choice in the matter. The author concludes that the Abbey midwives have now experienced choice and control over their working environment and therefore feel the need to encompass this freedom for all aspects of their working lives, and this includes the choice of car. The source of discontent between members of the team is that the ex-community midwives have a choice of car model, size, specification and colour, whilst the ex-hospital midwives have no say in the choice of fleet cars.[17] Whilst it is possible to see the clear links between autonomy and choice in working practices and the desirability of choice in other areas of life, it is also the case that this conflict can be linked to Tuckman's (1965) 'forming' and 'storming' stages of team development. Team members need to arrive at a position where all can feel confident that they are equally valued and equally valuable, and this basic discrepancy over cars comes into conflict with that need.

The visible work

When asked how the new working patterns had impacted on family life, some of the responses from the midwives at interview were:

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17 This situation has now eased as the ex-community midwives have retired.

"The family has had to adapt and cope with my new working hours. They now need to take note when I am on-call as this may mean I am not around."
(Abbey midwife)

"Before, they used to know when to expect me home, now it is much more flexible and they miss the structure, but like the fact that I am around more."
(Abbey midwife)

"My husband never complained when I did night duty, but if I am called out in the night he does not like it, he says it worries him when I am out at night."
(Abbey midwife)

"My husband complains I bring my work home now and that it invades our private life, but then so does his work. There again, he has always done it, I suppose, and now he is having to get used to this new working arrangement."
(Abbey midwife)

Thus, the author concludes that for these midwives, in the past, work was carried out in the hospital, but to the family it was 'invisible' work. From the time they left home and later returned, they did something called 'midwifery', but both partners and families had little insight into the 'real' work of these midwives. Since working in the MGP, these midwives have been based at home, and flexible working means that the family have become much more aware of the nature of midwifery work. Suddenly, the midwives' work has become 'visible' to their partners and families. Authors such as Oakley (1974) have illustrated the invisible nature of women's work and the consequent lower monetary value and esteem given to these activities.

Another aspect of their work that has changed is that, now they are based at home, a lot of the administrative work is done from home. Once again this adds to the visibility of their work, as does the use of the phone. All bookings and appointments are made over the phone, as is the handing over of work from one midwife to another at the end of the day. The midwives perceive this as part of the flexibility of the job, allowing them to

plan and structure their day and, at times, change arrangements as the need arises. The midwives see the use of the phone as a valuable part of their working day and do not consider it an intrusion. Their families, however, view it from the point of view of an intrusion that is not always welcomed. Some of the comments by the Abbey midwives at interview are:

> *"In order to keep the peace I have become a secret telephone call maker."*
> (Abbey midwife)

> *"I have resorted to taking my mobile out in the garden and wander about making appointments, etc."*
> (Abbey midwife)

> *"This issue has provoked many arguments at home. It's all right for him to monopolise the phone all evening with 'work stuff', but he gets upset if I do it. Well, now I use the mobile and go into another room."*
> (Abbey midwife)

As time has gone on, the families seem to have adapted to the new working patterns and now compromise and harmony prevails most times. It seems that, after the initial period of settling in, the families have become accustomed to the new working ways.

Another consequence of the now 'visible' work of midwifery for the Abbey midwives is that their partners are much more aware of the physical demands but, more importantly, of the emotional demands that the job makes. One midwife made the following comment:

> *"I think he suddenly sees me as a midwife and how totally consuming it can be. He then gets very protective and argues I should get better pay for all the effort and inconvenience to me."*
> (Abbey midwife)

> *"He used to consider I was very moody when coming home as I was on a 'high' after a delivery that went well but in a dark mood if the outcome was sad. Now we seem to share things*

more, he seems more interested and seems to appreciate the work we do."

(Abbey midwife)

It therefore seems that placing the work base at home has made midwifery work more visible to the families of the Abbey midwives, and the midwives are reporting more support and understanding from their partners and families. This provides these midwives with an extended source of support and understanding, whilst in the past, they had to rely on their colleagues.

The impact on family/personal life

The new way of working, with a flexible timeframe that allows these midwives to organise and structure their working day, has been discussed throughout this work. Having no strict shift patterns to adhere to means that they are able to exert choice and control over their domestic and working environments. This is seen in the way they manipulate the systems in order to care for the women they choose, the conspiratorial alliance between women and midwives that manipulates the system of borders and allocation of the women they will care for (as discussed in Chapters 6 and 7). It is also seen in the arrangement of their working day. Those midwives who prefer to work mornings make their appointments for this time and usually finish their midwifery day by early afternoon. The only time this is interfered with is when this midwife has a lady go into labour or there is a staffing crisis in the team. This has allowed the midwives to organise their time to best suit their personal, work and family needs. The other big difference is that, before, once the shift started they were committed to that time in hospital; now, they can interrupt their working day and slot in personal agendas or family commitments to later resume work. A selection of supporting comments gleaned from interview are:

> *"I love working like this, I have most afternoons to myself and feel so much better for it."*
> (Abbey midwife)

> *"I can now do so much more with the kids. I can drop them off to school then go to work. If I am working beyond school's leaving time I pick them up, drop them off at my friend and then carry on with work. It's brilliant!"*
> (Abbey midwife)

> *"I just would not change this for anything. I can organise not only my day but my life, and fit work in with everything else and not be constantly juggling life and work."*
> (Abbey midwife)

These midwives have developed the ability to use the opportunities of flexible time to best maximise juggling family/personal and work life; therefore, these midwives are incorporating rather than separating their roles. This is echoed in Walsh's (2004) study which describes just how midwives working in this way are able to incorporate family, personal and work life, striking a comfortable balance that enhances the individual. This is in contrast to the character of industrialised societies, where each element of time is fragmented and separated to accommodate personal/work/family agendas (Frankenberg, 2000).

Stevens and McCourt (2002) found that midwives working with a personal caseload, similar to the Abbey MGP, "described immense satisfaction" from working in such a flexible manner. But just like the Abbey midwives, the midwives in this study were aware of the 'long hauls' when, for example, they were called out to a birth after working all day.

> "These times were balanced by the quiet periods, when they were free to relax or to use their time in other ways. The midwives needed to learn to use this flexibility, to take the time that was theirs without guilt or making work" (Stevens and McCourt, 2002, p.114).

This feeling of guilt during the quiet times is something the Abbey midwives also encountered and have had to work hard at accepting. The following comments gained at interview illustrate this point:

> *"I suppose one of the most difficult things I have had to adjust to is not feeling guilty when I have done all my work, asked all my colleagues if I am able to help then and then all I have to do is wait for a call if I should be required. I can then do things at home or catch up with 'life'. It feels so strange to be able to do this. I feel guilty I am not doing, you know... work".*
> (Abbey midwife)

> *"For so many years going to work always means, you know, 'doing things', even when all was quiet on the labour ward you were kept busy 'doing'. We would have to stock up, clean equipment, help on other wards/areas. You were 'always' busy 'doing'. Now I find that there are occasions when there is no work and I can get on with home/personal stuff like shopping, the gym, cleaning, etc with my phone on, just in case. It has taken a long time for me to lose that sense of guilt."*
> (Abbey midwife)

It has, in effect, taken them four years to stop feeling guilty when there is no work for them to do. Conversely, they had no problems, other than fatigue, in working the long hours. Both Melia (1982) and Menzies (1989) have reported the need to keep busy, because not to do so generates a feeling of guilt.

Some of the Abbey midwives have commented that now their work is more 'visible' to their partners and families, they seem to be more aware of the nature of the job and the demands work makes on these midwives. As mentioned above, leaving the house in the middle of the night to attend a lonely rural address for a home birth has caused some partners to become concerned and protective towards the midwives. A number of the Abbey midwives also reported that the family shared in the household duties more often and, in their way, tried to lighten the midwives' workload.

The team and the families

The Abbey midwives have been working as a team for some years now and have got to know each other very well. Because they have the continuity of relationship with each other, they have also met and know each other's families. This enhances the bonds of the team members and, in times of family crisis for one member, there are always volunteers to cover so the individual midwife may attend to the crisis at a moment's notice. The following comments, gained at interview, illustrate this point:

> *"It's great not to have to worry when one of the kids has a problem, as one of the team will step in to help. They are a great bunch!"*
>
> (Abbey midwife)

> *"Before we started I was worried that with young children I would not manage, but in fact it's ideal because I can do most things with them and in a crisis I am there with them. I could not do all this without the support from my colleagues working in this way."*
>
> (Abbey midwife)

During the time that the Trust threatened to withdraw the service, not only did the public and the women they cared for rally to support them, but the midwives' families proved very supportive, joining in the protest marches and signing petitions. From time to time, the team meet for social gatherings and family members are made welcome. The larger group of family members has, in fact, developed into a close knit small community that provides encouragement and support to the Abbey midwives.

Personal development

When interviewing the Abbey midwives for this subject, the participants spoke with enthusiasm and delight at the transformation noticed in themselves and often commented on by their partners. Needless to say, developing professionally into a more assertive, confident midwife also influences the persona of their personal life. The

Abbey midwives spoke of those aspects (discussed in Chapters 6 and 7) as developments in their professional field that have also become part of their personal development, such as:

> *"My husband has noticed just how much more confident I have become. I am now able to do things that before, well... I would wait for him to tell me, now I just go ahead and do it."*
> (Abbey midwife)

> *"I am much more assertive now, because, I will tackle a complaint without hesitation, a thing I would leave for my husband to do."*
> (Abbey midwife)

> *"I feel so much more confident in myself. I notice it when dealing with the kids. I would feel anxious about the decisions I had made, now I don't feel so anxious so often."*
> (Abbey midwife)

> *"I suppose the biggest change I have noticed is that now I have settled into this way of working I feel good about myself. I am content, I am more confident and therefore happy."*
> (Abbey midwife)

The one recurring comment made about personal development is confidence. Every single Abbey midwife mentioned it at interview in a positive manner. Confidence, the dictionary (Kirkpartrick, 1983) tells us, is "firm trust or belief", and for these midwives the provision of control, that in turn generates choice, has developed in them not only a confidence in themselves as midwives and in themselves as individuals, but also in every other aspect of their personal lives.

The Abbey midwives have developed a sense of personal involvement with the women they care for, and a sense of investment in the relationships that nurtured the maturity of themselves as individuals. This sense of personal involvement was very challenging and they had to learn and develop an appropriate balance in acting as a facilitator and enabler, rather than feeding a dependent relationship (Stevens and McCourt, 2002).

Inevitably this took some time, but experience and reflection has helped them gain insight into avoiding dependency.

As mentioned above, the other qualities described as part of their professional development are assertiveness, motivation, interest and empowerment. The Abbey midwives acknowledge that these aspects of their characters, developed professionally, have also become internalised as part of their personalities.

The negative side of control and choice

In undertaking a study such as this, the author argues that the whole picture should be presented, even at the risk of causing discomfort. During her observations as a researcher, the author was aware that in some circumstances, there is a negative aspect to working as flexible midwives in an MGP. When midwives gain an element of control over their working environment, it is by necessity based on trust. Flexible working means no timetables to check-up with and, as these midwives move freely between the hospital and community, management have to rely on trust that all time claimed is correct. However, it is up to each individual midwife's interpretation of the concept of truth that is reflected in time claimed. Therefore, potentially it is open to abuse, but systems to eliminate abuse will also remove control and choice from the midwives.

Gaining some control can often generate a desire for more control over other aspects of work. We have already seen the Abbey midwives' manipulation of the system and conspiracy with clients described above (refer to Chapters 6 and 7). When having to either cover for sickness or come into the hospital for what is perceived to be routine work, there may have been occasions when the justification of too many visits and no

time in which to come to the hospital, may be perceived as not being strictly true. Pettinger states that:

> "Confidence and trust are affected by the balance of truth (the extent to which communications and interactions take place on an overt or covert basis) and, above all, the use of direct and indirect language" (2000, p.3).

The use of language for the Abbey midwives is to say that they are far too busy out in the community to come into the hospital, when in fact they not may be saying 'I can't come in' but more 'I do not wish to come in'. The argument is that the Abbey midwives, in having gained some control over their working environment, have gained empowerment and are able to monitor and work at a personal optimum to ensure a good service at all times - therefore, not allowing themselves to become overwhelmed by work in times of need for the team. In doing this, they are confident and assertive in risking a confrontation with management to justify their needs. Clearly though, this has some difficult consequences for those needing to co-ordinate a fragmented service based on a number of potentially conflicting models.

Changes to lifestyle

Moving away from the confines of a hospital environment and working such flexible hours has necessitated some adjustments in lifestyle for the Abbey midwives. One of the first identified causes of some stress was adjusting to having regular on-calls. This was particularly so for the midwives within the group who had no experience of community work. For some considerable time they stayed at home waiting for the phone to ring and, in some cases, had difficulty sleeping because they expected to be called and became concerned that they would not hear the phone once asleep. The following comments, gained at interview, illustrate this point:

"I remember so well that first on-call. I did not sleep much at all. I just lay there staring at the phone, expecting it to ring at any second. When the alarm sounded I had only just dozed off and I was almost furious that I had not been called! All that wasted effort!!"

(Abbey midwife)

"It took me months to learn to relax when on-call. I just sat there all evening glaring at the phone, daring it to ring and not hearing the telly, unable to concentrate an anything. It was such a relief when the stupid thing rang..."

(Abbey midwife)

Over time, the Abbey midwives have become accustomed to the on-calls and have relaxed considerably, able to continue with their normal activities and still maintain the availability to the service. Comments as below illustrate this point:

"I now have a personal rule. When I am on call the mobile phone is on and I am a midwife. But still able to carry on with a social life. It means all my friends are advised I am on-call and my kit and uniform are in the car to be able to respond if required. If the family come we take both cars so that no-one is dependent on me on those days. It's great, I can carry on as usual now."

(Abbey midwife)

"I have a golden rule. When I am working I am a midwife. When I am not working I am Mum, wife, party animal, social being and person. I do not allow the midwife to intrude upon my personal life. It is hard at times but essential for me to keep sane."

(Abbey midwife)

The essential change happened when they realised that they needed to change their focus from expecting to be called to not expecting to be called, yet ready to respond if required. This aspect of adaptation has been confirmed in the study undertaken by Stevens and McCourt (2002).

Responsibilities

In searching for a better understanding of the term 'responsibility', the author has referred to the dictionary (Kirkpartrick, 1983, p.876), which provides the definition of "To be answerable. Liable to be called to account. Being in charge or control. Deserving the blame or credit". Each of the Abbey midwives assumes responsibility for the women on their caseload. Whilst in the traditional system the community midwives cared for the vast majority of their women during the antenatal and postnatal period, they also shared responsibility with the GP and obstetricians. Now, the Abbey midwives found themselves totally responsible for the care of their women, regardless of risk and, in many cases, the women opted for midwife-only led care. In the early days, this responsibility generated some stress:

> *"I suddenly realised that I was the only one she* [the woman] *would see. It was all up to me. I gave her every piece of advice I had to give 'just in case'. The poor woman must have been totally overwhelmed with information. But I felt driven to adopt a 'belt and braces' approach because I could not cope with the responsibility."*
>
> (Abbey midwife)

Once again, it was the element of time that helped the Abbey midwives assume the responsibility of their role. One of the important elements that responsibility brings is gaining the knowledge of when to refer and call for help. In other words, the midwife needs to know very precisely where her professional boundaries lie. There needs to be an acknowledgement that other professionals may be able to help and multidisciplinary working is a key element of professional responsibility. The initial anxieties experienced by Abbey midwives in this area, highlights the fact that though recognised as part of the role of the midwife, in fact within the traditional systems multidisciplinary working is considerably underdeveloped.

At the beginning, the Abbey midwives reported taking on too much responsibility and found it very difficult to share or 'let go'. The following comments are examples gained at interview:

> *"I felt so responsible for all their care that even when I referred them to others, I was still trying to do it all, you know... I had to learn to let go or I would end up mad with so much stress."*
>
> (Abbey midwife)

> *"In the beginning, I just could not walk away, even when tired after all those hours I wanted to stay, even when my common sense told me I had to leave and get some rest. The sense of responsibility was very heavy on our shoulders."*
>
> (Abbey midwife)

> *"Where I had a problem was with the women who have had a bad outcome. I visit often to support but then I cannot 'let go'; I feel I need to be there, silly really, because eventually they have to learn to do without us, but I know it was me that needed to see they were getting over things. Now it's a lot easier. I have learned to draw that line across and move on, but it was very difficult in the beginning."*
>
> (Abbey midwife)

Yet time, collegial support and experience that is firmly based on a trusting relationship between the midwife and the woman, has allowed the Abbey midwives to develop a sense of balance between overwhelming responsibility and professional responsibility.

Another point to note is concerning sickness absence, where an increased sense of responsibility has meant that the Abbey midwives find it difficult to hand over work to their colleagues, because they know they are already busy and now they will have even more work to handle. In the author's role as manager, her observations and experience have led her to note that casual absence is much lower in the MGPs. This is in contrast to the hospital environment, where some midwives pass on responsibility to others and admit from time to time that they have no hesitation in taking a day's absence if work

interferes with their social life or they just don't feel like facing up to work (Stevens and McCourt, 2002). The following comments illustrate this point:

> *"I find I cannot go off sick now, well... not like I used to before. You know that your colleague will have to do her work as well as yours and you feel so guilty that it is easier just to keep going."*
>
> (Abbey midwife)

> *"I used to have to fit my social life around work but now I find it very difficult to even ask for change of day off, specially when you of course know just how busy everyone is."*
>
> (Abbey midwife)

These findings correlate to the work undertaken by Stevens and McCourt, in which they state that:

> "The volunteers tended to assume too much responsibility: for example, working for excessively long periods by providing exclusive care throughout a prolonged labour, working when sick or feeling guilty when passing on work" (2002, p.118).

The Abbey midwives have had to accept that they are not indispensable and that the work will go on with or without them. Accepting this premise has now allowed them to relax a lot more, and gain a better balance between work and personal commitments.

Boundaries

Another learning curve for the Abbey midwives was to discern their professional boundaries. They found that the relationship with the mothers in their care engaged them emotionally. This had the effect of drawing them into the women's everyday lives, with all its problems and vicissitudes. This emotional engagement is essential because it teaches humility to the professional. Professional people risk becoming arrogant because of the 'special' knowledge they consider they have. The reality is that the women are not so very interested in this knowledge, vital as they may consider it to be,

but instead focus on the acts of emotional engagement that really take them through the experience they are living through (Greco, 2002).

This had the effect of blurring the professional boundaries for the Abbey midwives and, over time, they had to learn to encourage independence and not foster dependence. Each individual midwife had to undertake a reflective introspective journey, which allowed the development of her personal professional boundaries. This is an area that now, with hindsight, the Abbey midwives admit was perhaps one of the more difficult for them:

> *"I have had to learn just when to give of myself, how much to give so that I have some left for the family and even, you know, for me. It has been very difficult because I have felt so guilty at times..."*
>
> (Abbey midwife)

> *"I know we have had each other to support and encourage, but it would have helped if we had a formal support network to access as we could have saved ourselves a lot of anxiety, stress and heartache..."*
>
> (Abbey midwife)

The Abbey midwives have had to establish personal professional boundaries, and have discovered that they are totally different from the hospital or traditional community midwives. This has now added to their feelings of difference and alienation from the traditional system of delivery of maternity services. The following comment, gained at interview, illustrates this point:

> *"I have noticed that I have come such a long way from the midwife I used to be. I feel that I have developed and matured so much that I almost don't speak the same language as my colleagues in the hospital. I know if I ever told them this they would say that I am 'stuck up' and a snob but our experiences are so different and deep and meaningful for each of us that they inevitably change you."*
>
> (Abbey midwife)

This study demonstrates that the Abbey midwives are evolving into a different kind of midwife. They are able to work in what Hunter (2002) has called the 'with woman' model. This means that they are able to place the woman and her family at the very centre of their focus, and are less distracted by the demands of the organisation than their colleagues working in the hospital. However, it also means that, for those midwives who live in families themselves, a certain amount of re-shaping of family life is necessary to accommodate the new pattern of working. Sandall (1997) comments that emotional and social support at home is a key element to preventing burnout for midwives working in the continuity of carer model. Although this thesis reports no cases where any midwife's family life was permanently negatively affected by the changed demands of the work, it is not difficult to imagine cases where the accommodation to be made exceeded what was possible for the family.

In the final chapter, the author generates a conclusion to this thesis.

Chapter 10

Concluding Chapter

Policy

As described in Chapter 2 of this study, the Winterton Report (1992) and the Report of the Expert Maternity Group, 'Changing Childbirth' (DoH, 1993) set out the government's policy on granting women the choice, control and continuity of maternity care that they, the consumers of the service, had demanded. However, it was left to each Health Authority and Trust to implement the policy, with no extra cash to fund and support any changes. This generated a flurry of ideas and pilot schemes, but unfortunately, through lack of funding, the majority have now been recalled (Rosser, 1997).

In this study, the author describes how the local Trust set out to implement this policy. One aspect highlighted by the author is the divide that has developed between the midwives working in the hospital and the Abbey MGP midwives. This chapter demonstrates how both these groups of midwives consider that they are implementing the policy.

Policy ethnography

Although this study set out to observe how a group of midwives would commence working in a different environment, in fact it is much broader than that. It looks at a national government policy, 'Changing Childbirth' (DoH, 1993), and comments on how the local midwives have coped with implementing it. The work of Lipsky (1983) comments that politicians, national committees and government agencies may formulate the policies, but it is the public sector worker who has to wrestle with attempting to

implement these policies. He also describes just how the 'street-level bureaucrat' will adapt and modify the policy to fit the working environment and ethos he/she is faced with. This study describes, in Chapters 6 and 7, the adaptation, manipulation and conspiracy with the women that the Abbey midwives use to adapt the 'Changing Childbirth' report (DoH, 1993) and to implement certain aspects of the policy contained within it.

In this study, policy ethnography has granted the author the chance to observe just how the local midwives interpreted and implemented the principles of the 'Changing Childbirth' (DoH, 1993) policy. Both the hospital/community midwives and the MGPs believe they have interpreted this policy, but it is clear that this has happened in very different ways in the different contexts. The evidence submitted by the author in this study demonstrates that the MGP version of midwifery might be viewed as taking forward the spirit of the policy as well as the letter, as it allows the Abbey midwives to develop a real partnership with the women. These midwives are able to practise with more independence and the relationships established with their women underpin their job satisfaction. As described in Chapters 6 and 7, the relationships with the women have allowed these midwives to gain in confidence and empowerment to adapt the policy to fit the circumstances they are faced with and the desires of the women in their care, confirming many of the insights of Lipsky's (1983) work. Thus, the contrasting philosophies of both the hospital/community and Abbey midwives provide the opportunity to expose students to these different cultures.

Entry into the profession

The student midwife's curriculum is designed to deliver a professional, competent, 'fit for practice' individual who, at the point of registration, will be capable of working in

all areas/departments of midwifery. The Nursing and Midwifery Council state in their 'Guiding Principles for Midwifery Competencies' (NMC, 2005) that:

> "Programmes of education must be designed to prepare the student to practice safely and effectively so that, on registration the student can assume the responsibilities and accountability for their practice as a midwife."

Indeed, this philosophy is continued throughout the individual midwife's career and, from time to time, she may be allocated to work in a different area. A midwife may be required to work in antenatal inpatient, day assessment units or clinics, the postnatal wards, birthing units, midwife-led units and community work, as well as the labour ward with normal labours, medical complications, operative procedures, water births, multiple births, etc. The midwife's role also encompasses undertaking ultrasounds, care of bereaved parents, working in 'Sure Start' deprived areas with other agencies, child protection work, and these are but a few of the vast array of skills a midwife needs to develop in order to practice.

'A midwife is a midwife is a midwife' has long been the 'cri de coeur' for the profession. In the words of Dennett (2001), "a multi-skilled practitioner able to deliver care in any setting". Once the newly qualified midwife settles into work and moves around from area to area, she discovers that in order to maintain 'all' her skills she needs to constantly up-date and, as more and more areas of practice are added on to the midwife's brief, time to achieve a realistic up-date becomes a very rare commodity. There are times when an individual midwife finds a special interest, but risks having to make a choice between remaining a good 'all rounder' or specialising in the area of her interest and thus risking losing her skills in other areas. As demonstrated in this study, the Abbey midwives have a very mixed caseload and are able to perform in every area

of midwifery. Their work is so very varied that it maintains their interest and enhances job satisfaction by providing such a vast variety of experiences.

Another phrase that midwifery uses as its 'raison d'être' is the meaning of the word midwife: 'with woman'. This is embraced at all levels and in all midwifery ideology, but the reality confronting most midwives today is that this is not always achieved, particularly in the hospital setting. The modern midwife working within the NHS finds herself frequently at odds with this ideal. She will often be too tired, frustrated, de-motivated, unsupported and enveloped by policies, guidelines and procedures that are generated by the coalition of obstetric, anaesthetic and paediatric medical forces (Hunter, 2002). Therefore, the author will now focus on the hospital setting.

The hospital setting

The hospital is, in reality, where most midwives practise. This institution belongs to a greater one, the NHS. As an institution, the NHS has very strong hierarchies that are very well established and serve as powerhouses to interested parties. Since the achievement of professional status, the medical profession has been broadly divided into three separate groups. Historically, these three groups fit into the hierarchy that mirrors the social structures of the time. The physicians were Oxbridge educated and thus enjoyed first rank. Next in line were the surgeons, derived from the barber-surgeon but perceived as a 'craft', so consequently they were not allowed to join the physicians with the title 'Dr' but had to remain as 'Mr', thus reflecting their humble origins. Apothecaries (pharmacists) were no more than shopkeepers and therefore 'trade', not worthy to join the elite (Hunt and Symonds, 1996). During the nineteenth century, the consultants became the elite of the profession and the General Practitioners were perceived to be the failures at higher aspirations. This hierarchical division was very

strong and influenced the setting up of the NHS to ensure that the different groups retained their power (Hunt and Symonds, 1996).

The history of midwifery, by contrast, is much older, as the first reference to the profession can be found in the book of Genesis in The Bible. From earliest times, the roles of comforter, healer and midwife were undertaken by women. This continued throughout history until the later centuries when education developed; primarily a male pastime which was seen as supplementary to apprenticeship. This, then, in effect, excluded women from becoming doctors and they were therefore reduced to working as assistants (nurses). Midwives still retained the privilege of practice (because their fees were cheaper and therefore more affordable to the majority of the population) until the establishment of the NHS, when the average person could now 'afford' a doctor.

Thus the institution of the NHS is male, consultant dominated and the role of the midwife is not only subordinate to doctors but is now grouped together with nursing and almost lost in the larger numbers of this group. When obstetricians become more versed in their skills, they:

> "redefined normality in pregnancy and labour to justify the widespread practice of antenatal, intranatal and postnatal interventions, so that the need, as they perceived it, for most births to take place in hospital became inevitable" (Tew, 1990, p.9).

With this environment of 'control' exercised over the birthing process, it is little wonder that the midwife now finds herself at odds with her ideal of being 'with woman'. Once she enters the portals of the institution she is governed by 'it', and thus her loyalties to the women she cares for are constantly challenged. Midwives are therefore balancing the needs/demands of the institution with the women under their care. Kirkham (1999) comments that, when looking at the analysis undertaken by Freire (1972), it gives us

some insight into how, in the process of internalising the values of the more powerful group, the original characteristics of the oppressed group become negatively valued and perceived. Kirkham, in her study of midwifery culture in the NHS, states that "maternity services were required to be 'woman-centred' with 'empowered' women exercising 'informed choice'" (2003, p.1). She also paints the reality of the current situation facing midwifery in the NHS by saying:

> "If we repeat such words often enough we can come to believe they describe the service on offer. Yet the reality experienced by most women is one of compliance with 'choices' which are defined by the service" (Kirkham, 2003, p.1).

Therefore, the ideals expressed in the 'Changing Childbirth' report (DoH, 1993) are given credence in the rhetoric, when in fact the reality is very different. This dissonance is generated by the current arrangements for the delivery of maternity services. Exworthy and Halford argue that (as highlighted in Chapter 2):

> "Professionals justify their claims to autonomy and status in terms of their expert knowledge and skills, geared to effective performance of specialized tasks. In contrast, managers claim their privileges on the basis of institutionalised hierarchical authority, their primary objectives are organizational efficiency and they require other staff to comply with organizational rules and their managerial commands. They are agents or servants of corporate bodies rather than individual clients" (1999, p.26).

This highlights the difference between the theory and reality, and the conflicting focus of the professionals and management. Walsh identifies that:

> "while one-to-one support is lauded by all stakeholders in maternity care, it is rather ironic that the place of birth for most women makes this logistically impractical to apply" (2004, p.174).

Kirkham (2003) describes how maternity care is delivered using an industrial model to manage labour care and Walsh (2004) comments on the irreconcilable dilemma of one-to-one care in a centralised labour ward where the focus is on 'organisational efficiency'

and not 'clinical efficacy'. The active management of labour, so prevalent in the hospital environment, enables more births to be managed in the one big space (Walsh, 2004). The hospital midwives constantly work in this environment. The Abbey midwives, in contrast, have the opportunity to experience a high degree of professional autonomy. These midwives are so accustomed to the home birth environment and the true one-to-one care that even when they 'go into hospital' they are able to take the home one-to-one ethos with them. As described in this study, the author highlights how the Abbey midwives do not socialise with their colleagues on the labour ward but remain in the room with 'their women'. Hunter's (2002) study found that midwifery is in effect split into two distinct groups: 'with institution' and 'with woman'. It is the Abbey midwives who are able to be 'with woman' and even manage to preserve this principle when entering into the hospital environment, although, as we have seen, this preservation comes with associated costs, such as being socially excluded by the hospital midwives and their community colleagues.

The community setting

Community midwives in the traditional model meet the women in their care antenatally, in most cases for two visits. If the woman attends the same GP clinic where the midwife shares the antenatal work, she may be seen by community midwives on several occasions during her pregnancy. Unless the woman chooses to have her baby at home, she will not see community midwives until she is discharged from hospital.

Community midwives are able to know their women a little more than their hospital colleagues, but it is very much the vagaries of the off-duty that will dictate how many times a particular woman meets up with, or is delivered by, a particular midwife. Therefore, these midwives are able to provide only an element of individualised care. In

the local Trust, they do not come in to undertake clinical work in the hospital, unless requested to do so to support staff shortages, something that causes resentment and anxiety as they are working in an unfamiliar environment. Thus, this measure is used only as a last resort by management.

The Abbey midwives, as stated above, are able to seamlessly move between the community and hospital settings. These midwives have the opportunity to engage in a close relationship with their women and, as a result, the numbers of births undertaken in the women's homes have increased a great deal (from an average of 4% home deliveries in this area, prior to setting up the MGP, to an average in 2004 of 20% home deliveries). The element of continuity of carer is provided and achieved, often with collusion from both women and midwives, as described in Chapters 6 and 7, and forms a crucial element in the achievement of job satisfaction for the midwives, whilst it is also much appreciated by the mothers (see Appendix 5 for a selection of the women's feedback letters).

The MGP setting

These midwives have an individual caseload of both low and high risk women under their care and are based at home, but can work in both community and hospital settings. This study demonstrates just how the Abbey midwives have developed the work, to ensure they provide individualised care. The conspiracies, attachments and possessiveness that develop are clearly demonstrated in this study (Chapters 6, 7 and 8). The empowerment and advocacy that these in turn generate have also been described.

Thus, the Abbey midwives have developed a model of midwifery that can function in both the hospital and community setting. However, it is clear that the hospital setting, as

presently configured, presents many challenges for midwives working in this way. They also incorporate the extra dimension of the development and nurturing of a close relationship with the women under their care. These findings are supported by Hunter's (2002) work, that would place the Abbey midwives in the 'with woman' model because they are able to place the woman and her needs at the centre of their work focus.

The Abbey midwives have managed to remain somewhat detached and therefore more independent from the organisation they work with. This has allowed the ownership of their caseload and the development of their advocacy and negotiating skills as evidenced in this study. In remaining somewhat detached (both physically and philosophically) from the organisation, the Abbey midwives are able to manipulate their workload and work within policies and procedures with a more flexible approach, thus gaining an element of control over their work. As demonstrated by Sandall (1997), the ability to exert some control over their working environment protects them from the harmful effects of work-related stress. This study also demonstrates that the Abbey midwives have developed their very own community of practice (Wenger, 1998), by learning to operate differently in their own unique way and develop their own body of knowledge that furthermore contributes to the midwifery knowledge base.

The 'unseen' work

As highlighted in this study, so much of the Abbey midwives' work is undertaken 'unseen' by their hospital or community colleagues. When they work in the community they work alone or with an MGP colleague (for a birth at home), and when in hospital the same occurs, except when circumstances deviate from the normal and the Abbey midwives not only advise the doctor, but also their colleagues, of developments in the care of their women.

As reported in this study, the Abbey midwives are able to vary their work and practise in all aspects of midwifery care. They are, at times, removed from the intense all consuming emotional and political atmosphere of the institution, thus allowing these midwives an element of control over the issues that may affect them. Thus, their allegiance and loyalties are to the group and to the women, not the institution as evidenced in the study undertaken by Exworthy and Halford (1999).

This has generated and fuelled the 'them' and 'us' divide. Hunter describes this as a process of "intra-occupational boundary maintenance", stating that "midwives constructed boundaries related to their beliefs about good practice, using different strategies to make territorial claims" (2002, p.5). As described in Chapters 6, 7 and 8, this phenomenon is constantly present between the midwives working in the traditional model of the hospital/community and the midwives working in the MGPs. The Abbey midwives had experience of working in both the community and hospital settings before working as members of the MGP. However, their colleagues have no experience nor insight into working in an MGP, thus the unknown is open to criticism, and fear that this concept will be universally accepted for all the local workforce creates the fear of change and, therefore, elicits criticism. There is, as reported in this study, an element of professional jealousy often voiced by their hospital colleagues:

> *"You are so lucky to get away and drive around for a bit, with the radio on, collecting your thoughts before you come in or see your next visit. I wish I could get away..."*
>
> (field notes, hospital midwife)

> *"It must be so nice to have so many 'normal' births with no interference, and also all those you do at home where the atmosphere is so different and you see 'normal', here we are lucky if we get the odd normal delivery."*
>
> (field notes, hospital midwife)

In these comments, one can sense the desire of the hospital midwives to have the same opportunities to practise the vision of 'real midwifery' that the Abbey midwives are able to have.

A comparative analysis of maternity outcomes has not been carried out at local level, but thanks to the insights gained from this study, the author has been able to suggest that data is collected and analysed every year in order to ensure that the Abbey midwives' work becomes more visible to management and colleagues, even in this format. The statistics that have been available to the author relate to the number of home births undertaken by the Abbey midwives. They are presented in Table 10.1 below.

Table 10.1: Number of home births undertaken by Abbey midwives

Year (April - March)	Total Home Births (Trust wide)	Abbey MGP Home Births	Abbey % of Total
1998-1999	147	47	**32.0%**
1999-2000	120	41	**34.0%**
2000-2001	125	44	**35.2%**
2001-2002	113	44	**39.0%**
2002 -2003	110	37	**33.6%**
2003-2004	126	54	**42.0%**
2004-2005	128	44	**43.4%**

The 'new' midwife

This study describes the transformational journey undertaken by the Abbey midwives. They started out focused on such issues as cars, pay, allocation of holidays. These are all individual, inward-looking issues. However, as these midwives have gone through the process of team development, described by Tuckman (1965), and were able to

experience the development of trusting relationships with their colleagues and the women they cared for, they became woman focused. Each midwife in the Abbey MGP expresses her delight in describing aspects of the changes identified (Chapters 8 and 9). As an observer, the author can testify to this transformation in the words of this thesis. As highlighted by the evidence in this study, the Abbey midwives now express very different professional and personal identities from those they described when they set out to work in the MGP. Their personal, professional and collegial development has progressed along a continuum that has no end. The evolving Abbey midwife is very different from her community and hospital colleagues. As evidenced in this study, they are able to practise in a different way to their colleagues. They, in fact, are able to control and indeed select the elements of the work they will undertake and have, in this sense, broken away from the rigid control of the organisation and indeed, it can be argued that the Abbey midwives bridge the professional gap between organisational and private practice.

This ability to control not only their working environment but also their professional development, coupled with the strong relationship they have with their clients, provides the Abbey midwives with the deep joy of job satisfaction that is so often missing from the accounts of their colleagues and, as others have found (Sandall, 1997; Walsh, 2004), safeguards them from burnout. This study, therefore, suggests that the Abbey midwives have in fact developed their own unique midwifery culture that contains elements of their past experiences drawn from the traditional models their colleagues still work under, but also incorporates uniquely new features that furnish these midwives with such an abundance of job satisfaction.

Implications for midwifery

When this study was first conceived, the local Trust had established two MGPs as pilot studies in order to prove that the concept of moving the maternity service to a community service was safe and workable. It was recognised that this would ensure that the midwives were indeed 'with women' and accompany their own personal mixed caseload of women within the Trust's boundaries. It also provided a natural experiment which allowed for the exploration of the ways in which 'continuity of carer' was implemented at both sites. This was done with the idea of converting the whole service to MGPs but, as has been mentioned in this study, the political agenda, both local and national, intervened and the two MGPs have now been firmly established within the different models of care offered by the local maternity service.

The Abbey midwives have worked in this manner for nine years now and are well established both as a team and within the local services' framework. This in turn has allowed the researcher to observe the midwives whilst they go about their work. There is no doubt that these midwives feel very passionate about the way they work and the service that they are able to offer the women they care for. Likewise, the women themselves are very obviously delighted with the service and the feedback is very positive (see Appendix 5).

The study undertaken by Hunter (2002) states that both hospital and community midwives espoused the vision of working in or providing a service that adhered or conformed to the concept of the midwife being 'with woman'. When the MGPs are also included in the analysis, as this study demonstrates, it is the MGPs that are able to offer a service that not only is tailored to each individual woman and midwife, but also accommodates the requirements of the organisation. While control over their working

environment is now recognised as being crucial to the prevention of burnout (Sandall, 1997), it is becoming a much more important consideration in the current professional midwifery climate that is facing recruitment and retention problems. There are lessons to be learned from the experience of the MGP midwives that might well be deployed to alleviate some of the retention problems currently being experienced by midwifery.

This study demonstrates that the Abbey midwives have developed their own midwifery culture that differs from that of their hospital and community colleagues, but mirrors the culture developed by Team 'B', thus giving credence that, in this local area, the two MGPs have embraced and developed visions of midwifery that differ from each other, but are both arguably closer to the 'with woman' ideology of midwifery.

The history of midwifery is the narrative of a power struggle between midwifery, nursing and medicine, where midwifery is in fact constantly under fire and is now showing signs of a powerless group (Donnison, 1988; Tew, 1990). The author argues that this struggle will continue whilst midwifery is such an integral and intrinsic part of the organisation of health provision. The Abbey midwives have proved in this study that working some distance (conceptually and emotionally, not physically) away from the direct influence of the organisation allows for personal and professional development. Also, a work culture is allowed to evolve that is not only supportive for the midwives, but allows them control over their working environment, thus enhancing job satisfaction and guarding against the harmful effects of stress (Sandall, 1995).

Conclusion

Looking back

This study set out to observe the Abbey midwives going about their daily work. The interest was to ascertain if the Abbey midwives would develop a work culture that was different to the one displayed by both the hospital and community midwives.

In returning to the definition of 'culture', the author prefers the definition used by Williams:

> "a description of a particular way of life, which expresses certain meanings and values not only in art and learning but also in institutions and ordinary behaviour" (1961, p.23).

This study demonstrates that, indeed, the Abbey midwives have developed a unique, singular working culture that travels along a development continuum. The Abbey midwives work both in the hospital and community, but have developed a distinct and particular work culture. They traverse the hospital/community divide and offer a seamless service to the women in their care. Walsh (2004) found that the 'busyness' culture of a large hospital had disappeared in the Birth Centre and that midwives were able to focus solely on the one labouring woman. This is in effect what the Abbey midwives are able to contribute. They come into the large general hospital but remain with their women throughout labour, creating a totally focused oasis of tranquillity in the room. They are so focused on their women that they are able to resist the 'conveyer belt' mentality that pervades in large hospitals that is focused on organisational efficiency.

When the Abbey midwives first set out as a pilot scheme, they were given very few guidelines from the organisation and management, in order that they had the freedom to develop a way to do things in this new model of care. This study highlights the trials,

tribulations and triumphs these midwives underwent in order to survive and develop. As seen in the preceding chapters, these midwives have changed and evolved both personally and professionally but, perhaps most importantly, the team has withstood all the changes and challenges to continue to develop along its continuum (see Appendix 6 for a brief summary of reflective comments from the Abbey midwives).

Implications for local services

When the Abbey midwives set out to work as an MGP, they only had their past experience of the organisation they worked in, but have now developed a different model of care. It is solidly founded on the ideal of 'with woman' and, as an MGP, these midwives are able to nurture a close relationship with the women they care for. This is a vital element for both the midwives and the women. It is this element that provides the Abbey midwives their job satisfaction.

Unfortunately, due to both financial and political agendas, this model of care has not been introduced across the local Trust. Once again, organisational power is paying scant attention to the desires of both the midwives and the women. This results in inequality of service provision, and this fact is reflected in the comments made by some of the women:

> *"This system of the Abbey Group is brilliant, and should be promoted more widely to all areas."*
>
> (field notes, lady cared for by Abbey MGP, feedback letter)

> *"I had a wonderful experience thanks to the Abbey gang, but I am moving and unfortunately will no longer be in the area to benefit from this service."*
>
> (field notes, lady cared for by Abbey MGP, feedback letter)

The author would argue that the sense of injustice is reflected in the 'them' and 'us' divide that has developed between the Abbey midwives and their colleagues. This issue would be resolved at a stroke if all midwives worked in MGPs. This would provide a maternity service that was flexible and able to cope better with the peaks and troughs of workload demands. Staff would be available to work when work demands it, but equally when the quiet times are there, staff could use their time far more effectively. However, as this study has shown, there are significant demands made on individual midwives and their families if such a model is adopted, and a time period of adjustment would need to be planned for.

Therefore, this study demonstrates just how a group of individual midwives have undergone a transformational journey. Applying Tuckman's (1965) model of team development has proved invaluable in gaining insight into how these individuals progress towards a team concept that functions as a productive group, achieving their goals of providing an individualised service to the women in their care. The evidence of this study is that this theoretical framework provides managers of the service with the opportunity to offer support at appropriate times, for example, during the 'storming' phases that can be so unsettling for the individual as well as the group, and which are revisited from time to time (as discussed in Chapter 6). The author would recommend that, in the future, when preparing a group of individuals to work in a similar way to the Abbey midwives, service managers avail themselves of Tuckman's (1965) theoretical framework and provide the team members with an awareness of the theory, in order that they may gain insight into the influences on team dynamics. The author would also suggest that this theoretical awareness is re-visited from time to time as a measure to enhance team relationships.

The author acknowledges that this study is very focused on one MGP and would be interested to see a further study undertaken that compared the findings of this piece of work with other MGPs elsewhere. This would add credence to the call to make this model of care available as a choice for pregnant women nationwide.

Implications for the national agenda

Both the Winterton (1992) and 'Changing Childbirth' reports (1993) put childbirth on the national agenda. Unfortunately, though originally heralded with great enthusiasm by the midwifery profession, the lack of central funding to convert to a community-based service gradually generated the demise of these very ideals. This left the local Trust attempting to implement a new concept with no funding.

The evidence of this study suggests that the Abbey MGP and, indeed, Team 'B', have both proved to be very successful. They are not without their problems, but this does nothing but prove that the MGPs are functioning in reality. The Abbey midwives have settled into the team framework and gained the confidence to embrace change and welcome new members. The newcomers are able to integrate into the group very quickly; therefore the group is constantly evolving. Their work has been recognised by the Trust Board granting them a higher grade and the position of Group Leader continues to be rotational.

Thus, the future looks good for the Abbey MGP, which has established itself as an integral part of the local maternity service. It is much valued by the women and families it serves, and it is also valued by the midwives that provide the service. The Abbey midwives have evolved their very own working culture that provides them with

opportunities to establish trusting relationships with their clientele and gain immense job satisfaction.

Strengths and Limitations of this study

Every qualitative researcher has to arrive at the point of accepting that their piece of research is only a contribution to the body of knowledge. Having lived with this personal project for so many years, the author is at risk of perceiving this work as the most significant piece of research on offer. However, the reality is that this piece of work has limitations. In selecting ethnography as the research method, the author acknowledges the overtly subjective nature of this method, as discussed in Chapter 4. Deciding what data to select and analyse, what to comment on and how to describe the events featured, are all subjective and personal choices made by the author. The author's position in the organisation and the relationships and responses to her, personally, whilst on this project, are all influences that colour this thesis. The author acknowledges that another researcher undertaking a similar study in the organisation would offer an 'alternative' and 'different' understanding of how the Abbey midwives work. That is to say, neither alternative would be 'better', but there would undoubtedly be variation between the accounts produced.

Statement of bias: the author is aware that, given her early involvement with the development of the concept of MGPs in the local Trust, she is clearly committed to making this project work. However, she has been acutely aware of the potential for bias and has made every attempt to present her observations in an impartial way. She has made sure that safeguards were in place (see Chapter 4) and stands by the fact that this is the story of the development of a service in response to a national policy and the

midwives that implemented this policy, as seen through this author's observations, which possess their own validity nonetheless.

The author accepts that understanding gained through ethnography is reliant on the way the participants respond to the researcher, and there is the potential that people will 'filter' or colour what and how they say things in the presence of the researcher. As discussed in Chapter 4, care and checks have been put in place to ensure that findings are presented in an open and honest description and analysis of the events encountered. The author has always maintained transparency of thought and intent to facilitate the reader in making an informed judgement of the content and reliability of this thesis.

The length of time dedicated to data collection (six years) is a vital strength of this study. This allows for the 'pilot study' elements to be confirmed as the Abbey MGP was established as part of the models offered by the local Trust. A longitudinal study also offers reliability, as over time it is more likely that any form of pretence by an individual will eventually be lost. Time has also granted the author the opportunity to observe the Abbey midwives undergo the team development process described by Tuckman (1965), through all but the last of the categories and perceive that, in fact, this is a process that continuously moves backwards and forwards through the different categories and is never static.

Observation of the reality of the work of the Abbey midwives highlights the strategies employed by both women and midwives to achieve their goals. It also describes observed behaviour, not so far commented on in the literature, of the alliance and conspiracy of the women and midwives in order to achieve a desired outcome, that is, continuity of carer. The author employed observation, individual interviews and group

discussions that enabled triangulation of data collection and, in addition to this, the longitudinal dimension of this study has assisted in minimising the inherent subjectivity of ethnography.

Accordingly, this study is the account of the transformational journey undertaken by a small group of midwives that left the hospital environment and, for some time, remained inwardly focused. Once recognised as a group practice, these midwives were able to establish trusting relationships with the women in their care, thus transferring their focus to this relationship, which has totally transformed these midwives in all aspects of both their personal and professional persona. However, the author acknowledges that it is a small group of participants set in the wider context of the local Trust. Therefore, the findings are by nature indicative and not conclusive. It is clear, however, that these findings, together with other work referenced in this thesis, offer a clear description of the schism that divides midwifery and the inherent tension between developing modes of practice that meet the requirements of hospital-based midwifery and those which are orientated towards women who feel a need for an ongoing, personal relationship with the midwife who cares for them. It is also clear from this study that once women have experienced the benefits of the supportive, ongoing, relationship with a midwife that is facilitated by an MGP, they seek that on subsequent occasions. These are undoubtedly insights that could beneficially be incorporated into midwifery training.

If students midwives are prepared in training to face this clash of midwifery cultures, it may well be possible to equip them better to make rational, woman-centred decisions about how they choose to practise and what the consequences of those choices might be for themselves as practitioners of the future, the service and future development of midwifery as a profession and for the women who use the service. Students who have

experienced significant time in an alternative midwifery culture may be better equipped to challenge the dominance of the medicalisation of birth.

As to the future, the author is emboldened by the enduring memory of asking individual Abbey midwives at the end of a very long day and most of the night working, if they would consider trading the exhaustion felt at that very moment for the comfort of the seven and a half hour shift in hospital, and a universal response of:

"Never!!!!!!!!!!!!!!!"

Appendix 1: Access

Celia Coulson
Address

Mrs A.B.
Head of Midwifery
Address

Date

Dear……..

As discussed with you at our meeting on Friday, I shall be undertaking my research using an ethnographic approach. This project will take six years to complete. As you know I intend to observe one of the Midwifery Group Practices and I require your consent to approach them and enlist their support for this project. Participation will be totally voluntary and anonymity will be assured. I am also seeking the Trust's Ethics Committee approval for this project and shall send you a copy of their letter. Thank you for your support and encouragement.

Yours sincerely,

Celia Coulson

Appendix 2: Ethical Approval

Date 11th December 1998
Our reference Ethics ref: June 1998
Your reference R&D ref: N031/98
Department

Dear Ms Coulson

Re: The culture developed by midwives working in a midwifery group practice

I am writing to let you know that your project was approved to proceed by The Research and Development Steering Group at its meeting on the 8th December 1998. Would you please let us know the length of time for each of the midwives to help you in your research – you can contact me on (01206) 832649.

The committee would like to receive details of your conclusions, and any recommendations which the Trust may wish to adopt, upon completion.

May I take this opportunity to wish you good luck with your research.

Kind regards

Yours sincerely

Susan Smith

Dr Susan Smith (PhD)
Research and Development Co-ordinator

New project.....

All Staff

A great opportunity to observe and describe just how the new concept of Midwifery Group Practice works in the reality of working life is to commence in November 1996. Celia Coulson is to undertake a study base on observation over six years. This will form part of her Thesis for a doctorate. Any information or discussion can be obtained by contacting Celia on extension 1686. Alternatively please feel free to write to Celia with your comments, ideas and suggestions.

Appendix 4: Data Collection Methods Used

Table A4

Interviews

6 months from start of MGP – 10 midwives
1 year – 9 midwives
2 year – 8 midwives
3 year – 9 midwives
4 year – 7 midwives
5 year – 8 midwives
6 year – 8 midwives

Exit interviews - 2 midwives

Interviews were conducted on-to-one away from the work environment, on neutral surroundings. All interviews were tape recorded. Open ended questions. Active listening.

Meetings

10 Abbey team meetings attended. Open discussion used on a variety of subjects. Clarification of issues raised in the meetings sought. Notes made in field notes diary immediately after the meeting.

Management meetings. These occurred on a regular basis and comments/ discussions involving the Abbey midwives were annotated in field notes immediately after the meeting.

Social events

Invited to attend lunch in a local venue with small group of Abbey midwives. This was done on four occasions with different midwives. Notes made in field notes diary immediately after the event. Midwives made aware I would be making notes and using data.

Political events

Used observation when attending the marches organised by the Abbey midwives when under threat of closure. Notes tape recorded on Dictaphone and transcribed.

Serendipity

Chance encounters generated a lot of data and proved very useful as they occurred in a variety of places, occasions and situations. On some occasions they where one-to-one encounters, on others they where small groups of two or more.

Field notes

These formed part of the formal recording of data. They where always made immediately after the event to be recorded.

Reflection

Abbey midwives were invited to submit a piece of reflective writing during the data collection time. Three midwives responded to this request.

The author kept a reflective diary. This was personal ruminations and comments that were made along the way. The author had the use of a voice activated Dictaphone and this equipment was usually left on the passenger seat of her car. This strategy allowed her to voice and record her ruminations at every opportunity and on a daily basis. This proved very useful and was transcribed into the reflective diary on a regular basis.

Observation

Every single opportunity was used to observe the Abbey midwives in all the variety of activities they perform and in all aspect of their daily work.

Appendix 5: Sample of Feedback Letters

Each of the following five feedback forms had an introductory page as below, followed by three pages for feedback and comments.

Introductory page:

Maternity Services,
Wing.

Dear

I hope that your experience before, during and after your baby's birth were as pleasant and enjoyable as possible.

As the Head of the Midwifery Services I am very interested in assessing consumer needs, and satisfaction.

If you have any comments to make please – good or bad – I would very much appreciate your taking the time to write them down overleaf. They may seem small or large but I do assure you that through this information we have already been able to improve a number of situations, and gain an idea of what our "consumers" think of the services provided.

The midwife will collect this letter from you when she completes your care, although if you prefer to forward this to me directly, then please do so.

Yours sincerely,

HEAD OF MIDWIFERY

SURNAME _____ UNIT NUMBER_____

WARD _____

DATE OF DELIVERY _____

Samples of feedback letters:

Letter 1

Would you please mark each area our of 10. 5 – satisfactory

Comments on Antenatal Care:

VERY PLEASED WITH CARE FROM THE TEAM of MIDWIVES THAT VISITED.
VISITS AT HOME WERE CONVENIENT AND COMFORTABLE FOR ME HAVING ALREADY GOT A 2 YR OLD.
MIDWIVES ALL KIND + REASSURING + ALWAYS READY WITH ADVICE + ANSWERS TO ANY QUESTIONS I HAD.

10/10

Comments on Care in Labour:
Did your birth go according to your own Birth Plan?
Did you feel consulted and informed during labour?

DIDN'T REALLY HAVE A BIRTH PLAN, ONLY TO BE IN HOSPITAL.
IT ALL HAPPENED QUICKLY + WAS LEFT TO LATE TO GET TO HOSPITAL.
MY HOME BIRTH HAPPENED WITHOUT ANY PROBLEMS. THE 2 MIDWIVES PRESENT WERE VERY FRIENDLY + REASSURING + TOOK GOOD CARE of ME BEFORE + AFTER THE BIRTH.

10/10

Cont

above 5 = more than; below 5 = less than.

Comments on after care of you and your baby:

BRILIANT AFTER CARE.
I'VE GOT NOTHING BUT PRAISE FOR
ALL THE MIDWIVES INVOLVED IN
MY PREGNANCY + BIRTH OF MY SON.
MY HUSBAND SECONDS THAT.

10 /10

Comments on continued care in the Community:

/10

General Comments on meals, comforts and any other matters:

Meals	/10
Cleanliness	/10
Comforts	/10

Please give to your midwife on her last visit or post back to me.
(See front page.)

Letter 2

Would you please mark each area our of 10. 5 – satisfactory

Comments on Antenatal Care:

10/10
It's lovelly having your midwife come to your home and having the same midwife each time.
came to me throughout my first pregnancy and this one, so i felt i really knew her and we had a Great relashonship which was nice as the birth drew nearer.

10/10

Comments on Care in Labour:
Did your birth go according to your own Birth Plan? yes
Did you feel consulted and informed during labour? yes

My first birth was the worst experience of my life - so this time round i was extremley nervous and tense.
i was amazed that i managed the whole labour on just Gas & air and there was me, my hvsband and throughout the whole delivery. in comparrison to my first labour i'd say this time round was fantastic and completley different in every single way.
i went in at 5pm - had Katy at 6.50pm and walked out at 8pm – what a differance
10/10

above 5 = more than; below 5 = less than.

Comments on after care of you and your baby:

Excellent - Well informed, looked after and available at anytime should I have any queeries, problems or questions.
Very happy.

10/10

Comments on continued care in the Community:

Again very good - I have met my health visitor and have been well informed of all the help & advice available to me. Unfortunately we are moving within the next few weeks to so I will no longer be in the area to benefit from this service.

10/10

General Comments on meals, comforts and any other matters:

Top marks to the Whole midwives
Staff - and I would like a special
'Thankyou' passed on to
for putting up with my fears, questions
and constant worries throughout the
whole nine months !!. I only hope that
if I have another child I could have her
again - She was fantastic.

Meals	/10
Cleanliness	/10
Comforts	/10

Please give to your midwife on her last visit or post back to me.
(See front page.)

Letter 3

Would you please mark each area our of 10. 5 – satisfactory

Comments on Antenatal Care:

I was under the Midwives scheme, but didn't get to see the same midwife as much as I would have liked.

6/10

Comments on Care in Labour:
Did your birth go according to your own Birth Plan?
Did you feel consulted and informed during labour?

I didn't have a Birth Plan. This was my second child. I am happy to say that this experience was a huge improvement on my first labour! I felt that I was informed and involved in decisions that were made, my partner also felt more involved and included. The midwife who delivered my baby was wonderful as was the anaesthatist!
A very positive experience!

9 /10

The student midwife was also excellent

Cont ➶

above 5 = more than; below 5 = less than.

Comments on after care of you and your baby:

I had to stay in hospital longer than I would have liked as baby was taken to SCBU. At times I felt that I was being a nuisance asking staff for help - this was evident by some of the responses I got. Perhaps I was expected to know more as this was my second child. My lifeline ~~was~~ whilst in the ward was the Midwives visits.

5 /10

Comments on continued care in the Community:

The care I have received in the community has been great!

8 /10

General Comments on meals, comforts and any other matters:

Restrictive visiting hours whilst an inpatient :- I appreciate that visiting has need to restrictive to allow Mum's + Baby's to rest. My husband is self employed and home isn't too close to the hospital. We don't have a huge network of people who can assist with looking after our other child. This meant that it was difficult at times for them to visit, then no sooner had they arrived the bell rang for end of visiting. It would have been nice if visiting could be open for partners.

Meals	6 /10
Cleanliness	6 /10
Comforts	6 /10

Please give to your midwife on her last visit or post back to me.
(See front page.)

Letter 4

Would you please mark each area our of 10. 5 – satisfactory

Comments on Antenatal Care:

Excellent.
It was reassuring to be able to contact ~~anyone~~ your own midwife or one of the team if you had any queries. Continuity of care was very important throughout my pregnancy & this was met by the midwifery team as ensured I met all the team members during antenatal care. 10/10

Comments on Care in Labour:

Did your birth go according to your own Birth Plan?
Did you feel consulted and informed during labour?

very happy with the care I received in labour. As I was under the care of the Midwifery team I knew my midwife & she was already aware of my past experiences of previous pregnancy/ labour & knew of my wishes prior to admission. This resulted in a very calm & controlled labour & delivery. 10/10

Cont

above 5 = more than; below 5 = less than.

Comments on after care of you and your baby:

It was good to be seen in hospital by the community team as this facilitated a smooth transition from hospital to home. However I felt that some of the hospital midwives regarded you as not really under their care. However some were very helpful.

7/10

Comments on continued care in the Community:

Excellent - I developed a few problems post-natally which sorted out immediately.

10/10

General Comments on meals, comforts and any other matters:

It would have been nice not to have had loud music playing in the corridor most of the day as I found this quite disturbing when trying to rest.

Meals	6	/10
Cleanliness	7	/10
Comforts	7	/10

Please give to your midwife on her last visit or post back to me.
(See front page.)

Letter 5

Would you please mark each area our of 10. 5 – satisfactory

Comments on Antenatal Care: ~~10/10~~

- great to have the freedom to choose between a GP based midwife and the team for the visits. I loved have no fuss, booked appt times in the beginning and then the more flexible appts later on in pregnancy when there was more time to be at home.
- all the midwives I dealt with were: approachable, friendly, caring and competent. I always felt well looked after.

10/10

Comments on Care in Labour:

Did your birth go according to your own Birth Plan? Yes

Did you feel consulted and informed during labour? Yes

Absolutely brilliant to have a home birth.!! The midwives were ace, I felt I knew all the options. I felt safe and also felt that I was given flexibility if I needed to change my mind.

I really liked the way how the midwives let everything happen at my pace. 10/10

Cont ↗

above 5 = more than; below 5 = less than.

Comments on after care of you and your baby:

this is my 3rd baby so I don't need lots of advice and info about caring for baby or myself – and the midwives appreciate this. They give me the info I need but don't overdo it.

10/10

Comments on continued care in the Community:

If this is the system of the team then it is brilliant. To have such continuity between community and hospital is really good and should be promoted more widely over the UK. Because I knew who the midwives were to be, I felt more confortable during the actual labor.

10/10

General Comments on meals, comforts and any other matters:

One more thing ....

I had an ECV at 37 weeks which was successful and I am very grateful for that as it allowed me to have a good home birth.

BUT I was in the CDS from 8.30 till 2pm which seems a very long time for a 20 minute procedure! I would have preferred knowing that it was going to take so long. It was also uncomfortable going without food and drink for so long.

Meals /10
Cleanliness /10
Comforts /10

Please give to your midwife on her last visit or post back to me.
(See front page.)

Appendix 6: Reflective Writings

This is a compilation of three individual pieces of reflection submitted by three Abbey Midwives.

Reflections…

Benefits/things learned form MGP

Increased confidence in practical, social and decision-making skills. Experience and consolidating practice in antenatal care, especially screening and diagnostic tests. Becoming more of an advocate and more assertive on behalf of the women, knowing their strengths and points of vulnerability, likes/dislikes, needs both physical and psychological.

Experience in home births. Gaining confidence in the fact that women (especially low risk) are able to labour positively, successfully and safely with little or no 'interference' or intervention by the midwife. To be bale to stand back and let women do what their bodies were designed to do, with their confidence and self esteem built and confirmed.

Having to make decisions independently often because I am on my own in the community (it is easy to 'lean' if only for another midwife to sanction personal decisions and choices). However, more aware of the value of peer support and other support.

Realising that as <u>my</u> confidence and skills develop/deepen, so the women/families themselves can rely on, trust and have confidence in me as their midwife. This in turn can produce/encourage more positive outcomes in the childbearing process both physically and psychologically.

There has developed a sense of 'mutual ownership' between midwives and families that is loosely held without dependence or dictatorship. There is a sense in which I am no longer an individual practicing midwifery but now feel more a 'midwife' that is 'with woman'.

There is less suturing done. Virtually no episiotomies. Seeing very few problems with neonatal jaundice. More sharing and empowerment in decision-making with mothers/partners and

obstetric staff. Discovering the real help offered/provided by paramedic services with home deliveries planned and unplanned. Discovering also how much women and partners appreciate having 'known midwife' during labour and delivery even if only met once before and this is also true of elective Caesarean Sections, makes the confident, relaxed and 'special'.

In seeing the parents/babies for longer period postnatally I am more aware of the effects early advice/help can have. Having to take more real responsibility for the advice and actions taken as a midwife.

Positive experience for seeing families' through whole process of pregnancy, childbirth and child care. Flexibility in working practice, not 'wasting time' on duty if no work available. Able to work more to individual needs which is based on fuller knowledge of parents, family and home/social situation(s).

Experience of dealing with problem families and families with problems. Sharing information to help and protect. Developing compassion and diplomacy!!. Developing more realistic relationships with GPs and other medical/caring disciplines and learning to values and sometimes educate them as well as learn from them.

Maintaining a sense of 'cutting edge' in all aspects of midwifery care as most are faced on a daily basis rather that on rotation (hospital) where it is easy to become 'rusty'.

Building close and independent relationships with team members. All are very individual in character, attitude and skills. To build on mutual respect and accepts each others strengths/weaknesses and 'foibles'.

Improved sense of direction to find my way around the patch as it is very easy to get lost!!.

Job satisfaction ++++++!!!.....

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