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MIDWIFE TO MID WÍF

A Study of Caseload Midwifery

Trudy Stevens

**A thesis submitted in partial fulfilment of the
requirements of Thames Valley University
for the degree of Doctor of Philosophy**

March 2002

This thesis is dedicated to Houwa Adam,
a foolhuma (traditional birth attendant) in the
Republic of The Maldives, who taught me midwifery.

ABSTRACT

This thesis explores the implications of individual caseload practice for midwives.

Over the past fifty years childbirth in England has become predominantly hospital orientated, with midwives forced to meet the needs of the institution rather than those of childbearing women. In 1994, a change in government policy for the maternity services attempted to address the dissatisfaction felt by mothers and midwives. The model of caseload midwifery was developed from their recommendations.

Midwifery retains an ideology of independent practice yet the reality of working in a subservient position to obstetricians and controlled by the dictates of an institution have been seen in some studies to have undermined midwives' practice. However, their willingness and ability to work in a more independent manner was questioned.

This study explored the implementation of caseload midwifery within a highly medicalised inner-city NHS maternity service. Working in partnership, within small groups, each midwife carried a caseload of 40 women per year. No longer based in the conventional hospital or community services, the midwives worked where and when appropriate, to meet the needs of their women.

The research was undertaken over 46 months using an ethnographic approach and a variety of data collection methods. The prolonged study period facilitated an understanding of the development of caseload practice from its implementation into an established service.

This thesis explores the adaptations the midwives needed to make on moving from conventional practice into caseload practice. Comparison of the difference services offers an understanding of the ways in which organisational features can influence the practice and meaning of midwifery. The control over and uses of time emerged as an important theme in this regard.

Of particular note was the high level of job satisfaction expressed by the caseload midwives and their consideration that this model enabled them to practice “*real midwifery*”, phenomena which are explored within the thesis. In working ‘with’ women, it is argued, the midwives developed a form of authority that had not been facilitated with the conventional services, and which contributed towards a new form of professionalism for the midwives.

Although considered by many to be independent and ‘isolationist’, the strengths of caseload practice were seen to be in the context of group and inter-professional relationships, and the relationships midwives formed with mothers and their families as their work became re-embedded in the society in which childbirth occurred and had its meaning.

ACKNOWLEDGEMENTS

This research, and the lessons learnt whilst undertaking it, could not have been possible without the good will, help and constant support of many people. In particular I would like to acknowledge the very significant contribution of three special groups:

The midwives working in the caseload project, whose courage in accepting the challenge of *Changing Childbirth* and the searchlight of the evaluation, and whose responsiveness to the prying questions of this ethnography, have enabled us to begin to understand what it really means to carry a caseload.

The midwives in the conventional service who also supported this study and myself during clinical practice, whilst continuing to provide care to childbearing women in circumstances that begged the question, why do they stay?

To Judith, Chris and Ray, without whose support, guidance and nourishment (academic and physical) this thesis would not have reached fruition.

Thank you.

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Derivation of the term *Mid Wif*

The derivation of the term 'Mid Wif' is reputed to be from the Anglo-Saxon 'mid' meaning with, 'wif' meaning women. However, prior to the invasion, the use of the two words together to mean childbirth attendant has not been verified.

Personal communication, Simon Keynes, Professor of Anglo-Saxon, Trinity College, Cambridge.

Mid = with. At the root of the various meanings lies the idea or association of being together

Wif = woman, female person

Bosworth, Joseph and Toller, Northcote T. 1898 An Anglo-Saxon Dictionary Oxford, Oxford University Press

'mid-wif' med forms may be due to influence of Latin medius, 'mediator' or mediación, mediáte

a) a midwife

b) a saint who aids women in childbirth

Kuhn S.M and Reidy J.(eds) 1975 Middle English Dictionary Michigan, University of Michigan Press

May also be written as:

Medewife	Medewyve	Meedwiif
Medwyf(e)	Mydwide	Mydwyf(e)
Medwif(e)	Myddewyffe	Mydewyf
Mydewif	Mydewyff	Midwyfe
Medewif	Meydvyyf	Midwife

1303 R.Brunne used the term "mydwyffe"

Oxford English Dictionary 2nd ed 1989

Use of codes

The exact words used by participants in this study have been offered as quotes to illustrate various points raised. These are presented in italics within quote marks. A code given with each substantial quote provides an indication of the source of such data. This contains three components: method of data collection used, category of individual, and individual identification number. The codes used are as follows:

<i>Method:</i>		i	interview
		fg.	focus group (interview)
		o	observation, or discussion held during observation period
		cc	corridor chat or informal meeting
		q	questionnaire response
<i>Category:</i>			
Midwife	pm	project midwife (caseload midwife) (om = 'original' project midwives) (nm = 'new' project midwives)	
	cm	community midwife	
	hm	hospital midwife	will be followed by grade E or G
	st.m	student midwife	
	AG	'Action Group' member	
Doctors	CO	consultant officer (not necessarily obstetricians)	
	SO	senior officer (SR or R)	
	JO	junior officer (SHO)	

Number: each participant was given a separate identification number. When more than one interview was conducted with the same individual and the quote is taken from the subsequent transcription this is indicated by .2 after the initial number.

Thus i.pm08.2 was the second (exit) interview conducted with project (caseload) midwife number 08.

fg.om.'97 was from the focus group interview held with the 'original' caseload midwives in 1997. As these were not recorded it was not always possible to identify the precise individual who spoke, although an indication is given when quotes are from different individuals.

Examples:

fg.anc.'95	=	focus group with antenatal clinic staff in 1995
fg.hm.'96	=	focus group hospital midwives (ward) 1996
i.hmG04	=	interview with G grade (sister) hospital midwife no.04
o.no3.cm.'95	=	observation no.3 with community midwife 1995
i.AG02.2.	=	second (exit) interview with Action Group member no.02.

Midwife to Mid wif

A study of caseload midwifery

Chapter 1

INTRODUCTION

This study concerns the care of childbearing women at the turn of the millennium. It relates to those who care for such mothers, the childbirth attendants, their work and the influence of the confines placed upon it. It is a study of a group of midwives who rejected conventional ways of working and accepted the challenge suggested by the government's Expert Maternity Group in their report, *Changing Childbirth* (DoH, 1993). In electing to work with an individual caseload of mothers, the midwives provided continuity of care and carer throughout each mother's childbearing experience.

The thesis draws from an ethnographic study of the implementation of caseload practice, focusing on the implications working within this model held for midwives. Although the study commenced when the model had just started, in lasting nearly four years it enabled identification of initial problems and features likely to be enduring to this style of practice.

Caseload practice proved a way of working that acknowledged the individuality of both mother and midwife. It also enabled the midwives to practice what they termed "*real midwifery*". In changing the midwives' orientation from institution to mother, caseload practice facilitated the movement from 'midwife' to 'mid wif', an Anglo-Saxon term, meaning 'with woman'.

This is also a study about the consequences of the change. Individuals cannot work in isolation from the context of their work. Such work is situated within the organisation that is entrusted to provide the service, and within the social context in which individuals live and work and childbirth has its being. Thus the change was likely to hold ramifications for other professionals working within the maternity service. Identification of these was also sought.

This introductory chapter offers an outline of the thesis content and development. Any discussion is meaningless without an understanding of the caseload model implemented and its effectiveness; thus the theory of the model and summary of the evaluation are presented first. The nature of the study, the findings and the implications, as developed in the subsequent chapters, are then outlined. Finally to aid clarity, definitions of the key concepts as used in this model are presented, in acknowledgement of the current confusion in the midwifery literature.

Caseload midwifery: the model

Caseload midwifery was implemented in November 1993 as a pilot project within an inner city maternity service delivered from two hospital sites. Although similar to independent midwifery practice, this model had not been used within the National Health Service. In view of the radical change involved, a robust evaluation was integral to the project development.

The work was undertaken as the first project of a newly established Midwifery Development Centre, a collaborative unit established within the Special Health Authority (SHA) with the College of Midwifery Education. A newly appointed Professor of Midwifery led the Centre, working closely with the Head of Maternity Services; the clinical side of the project remained the responsibility of the Clinical Directorate for Obstetrics and Gynaecology.

The principles of the project were developed and centred on five areas, detailed in Table.1.

Organisational features of the caseload practice project (summarised in Table 2)

The service was limited to mothers living in two postal districts. This enable the development to be run as a pilot in which comparisons could be made with conventional care delivered to mothers in adjacent postal districts.

Women living in the designated area wishing to register for maternity care at either of the two maternity units were offered midwifery care from the project, irrespective of existing or potential complications with their pregnancy or delivery. Twenty midwives, already employed by the SHA, each carried a caseload of 40 women per year. Their

caseload included a mixture of low- and high-risk pregnancies, a situation unlike other team midwifery or caseload models at the time. For ease of communication, midwives were 'linked' with one or more General Practitioner (GP) surgeries but, unlike community midwifery models, were not GP attached nor ran GP surgery-based antenatal clinics.

Table 1: Principles of caseload practice

- The provision of midwifery care within two postal districts, integrating hospital and community in a unique way, at both hospital sites.
- The provision of a named midwife for each women who will care for her throughout pregnancy, birth and the postnatal period. The one-to-one relationship will enable the midwife to be sensitive to the individual needs and choices of the women and families she supports.
- The promotion of excellence in midwifery practice, enabling midwives to use all their skills within their caseload and to develop them.
- The implementation of an academic environment which encourages personal and professional development utilising a system of peer review and support, providing direct and sensitive feedback to individual midwives through audit of practice.
- Evaluation of the project, both its processes and outcomes, with the assistance of an external committee of experienced researchers.

Source: 'The Way Forward' document. Cooke *et al* (1993)

Table 2: Organisational features of caseload practice

- 20 midwives, working in partnerships of 1 G & 1 F grade, within groups of 6/8 individuals,
- each providing ante-, intra- and post-partum midwifery care to 40 high- and low-risk women giving birth per year,
- offering midwifery-, GP- or obstetric-led care, in community or hospital

Discussion with each mother determined whether an individual's care was midwife-, GP- or obstetrician-led. However, each midwife was responsible for the midwifery care provided throughout pregnancy, labour and delivery, and the postnatal period for the women on her caseload. The place of care provision by the midwives was determined by each situation and maternal preference, the midwives working flexibly in women's homes, GP surgeries or either hospital. Care was thus provided when, where and how

best suited each individual situation. Midwives were not tied to time or place of work and contact was facilitated by the provision of mobile phones.

To support them in this arrangement, each midwife worked with a partner who would 'cover' for them, responding to calls and undertaking necessary work, when they chose to be 'unavailable'. This reciprocal arrangement was negotiated within each partnership rather than predetermined or 'rostered'. Although one midwife assumed responsibility for care, during the antenatal period each mother would meet and get to know both partners.

The midwifery partnerships were organised into three groups, two of six midwives and one of eight. These groups were formed for the purpose of further support, clear lines of communication, and regular peer review meetings in which practice issues would be discussed. Each partnership comprised a G grade and an F grade midwife, and co-ordination of each group was shared on a rotational basis between the G grade midwives.

A series of organisational targets were defined which reflected many of those of *Changing Childbirth*; see Table 3.

Table 3: Organisational Targets

- 95% of women to be attended by a midwife they know and have formed a relationship with for labour and delivery.
- Low risk women to be directly cared for by no more than six professionals in the course of their pregnancy.
- Over 75% of women to be cared for by their named midwife in labour.
- 75% of total antenatal visits to take place in the community.
- 50% of women to have midwifery-led care throughout.
- 75% of postnatal care to be by the named midwife
- No more than five professionals to provide midwifery-led care in the postnatal period.
- Peer review to be undertaken by practices themselves every two weeks.

Source: 'The Way Forward' document, Cooke *et al* (1993)

Profile of the clientele

In understanding the experiences of the caseload midwives, it is helpful to appreciate a profile of the mothers they were serving. This information was gained from their

questionnaire responses and analysis of the hospital information system. In comparison with the group served by the conventional service, caseload midwives were caring for a significantly different population in terms of class and ethnicity. Most of this difference was accounted for by care given to women using the smaller 'maternity unit', located in a more socially deprived neighbourhood than that served by the 'maternity hospital' (see chapter 3).

Although a proportion of the mothers came from professional, home-owning households, the midwives' catchment area included some large, and relatively deprived, housing estates. Mothers from the latter booked mainly at the smaller maternity unit so the population cared for by each unit was different. A number of refugees moving into the area increased the diversification of family structures and ethnic backgrounds the midwives worked with. On all criteria measured the midwives cared for mothers representing a more disadvantaged group who, based on epidemiological evidence about patterns of health, would be expected to have greater practical and health difficulties and needs for support (McCourt and Page, 1996).

The Evaluation

Clearly such a radically different form of midwifery practice held implications for mothers, midwives, and the maternity service. An extensive evaluation was designed as integral to the project, seeking to address the following questions:

1 Impact on the staff and service overall:

- How did the different groups of staff respond?
- How did the service handle such change?

2 Impact on women and families:

- What did women using the service think about their care?
- Did it affect their experience of childbirth or their emotional and physical wellbeing?

3 Clinical:

- Did the new service meet acceptable clinical standards?
- Did it have any impact on intervention rates?

4 Economic:

- What were the implications for resource use and was it affordable?

Although the service which implemented the project had a long history of undertaking research, this had been conducted by the medical staff using scientific paradigms in which the randomised controlled trial was seen as the gold standard. Such methodology was considered inappropriate in this evaluation in view of organisational difficulties, extra costs, and number of confounding variables that could potentially bias the results. An alternative protocol was developed utilising the following approaches:

- A target-based approach, to establish the extent to which specific organisational targets and clinical standards were met and to assess the use of economic resources.
- A descriptive approach, to document clients' experiences and responses to their care; and to describe the process of organisational change and its meaning to professionals.
- A comparative approach, to compare caseload midwifery care with the system of care it replaced.

The Evaluation Protocol (Page *et al*, 1994) detailed the variety of methods used. Tools were designed specifically under the guidance of an external team of experienced researchers, and the work conducted by a small team of local researchers in collaboration with specialised research units elsewhere. Ethics approval was sought and granted from the hospitals' Research Ethics Committee, and funding achieved from a various sources, most notably Johnson & Johnson.

The caseload midwives were clearly aware of the evaluation and full co-operation was an expectation of their selection. An advantage of using different approaches was the facility to check and counter check findings as they emerged against alternative perspectives, thus checking validity and enhancing understanding. The close co-operation of management, research teams and midwives facilitated feedback that proved mutually helpful to service and evaluation.

A subsequent, smaller study was conducted once the project had been assumed within the wider service management. This assessed whether the outcomes of the first cohort changed once the initial enthusiasm, or difficulties, of the pilot scheme had declined, and there had been some turnover of midwives. Data were collected between 1997-1998, a period which covered the end of the ethnographic study.

Findings of the evaluation

The evaluations findings are presented here as they help 'set the scene', indicating how the practice of the model related to the 'theory' in terms of the various outcomes measured. The report of the first evaluation was produced in 1996 (McCourt & Page, 1996) and the findings have been published in a variety of reports and journals (McCourt, 1996, 1997, 1998a, 1998b, 2000; McCourt *et al*, 1998; McCourt & Pearce, 2000; McCourt & Beake, 2001; Harper-Bulman & McCourt, 1997; Page *et al*, 1999; Piercy *et al*, 1996; Beake *et al*, 1998). The report of the follow-on study was published in July 2001 (Beake *et al*, 2001) and an overview of the clinical outcomes and maternal satisfaction in November 2001 (Page *et al*, 2001).

The findings of this second study indicate that the positive outcomes of the first cohort had been maintained over a period of time, and significantly improved in terms of length of labour, and reduction in caesarean section rates. The situation is complex and reference to the detailed reports recommended. However, to summarise:

- Women receiving caseload care saw fewer professionals overall (median 10 versus 19 in conventional care) and were more likely to know those they saw.
- The numbers cared for in labour by a 'known' midwife were high: 67% named midwife, 21% partner.
- A significantly lower rate of clinical interventions was associated with caseload care:
 - the caesarean section and assisted delivery rates were lower
 - fewer epidurals were given for pain relief
 - perineal damage was reduced.
- Audited standards of care were similar to control group. However, an observation study of the booking visit indicated qualitative differences, particularly in terms of information, choice and partnership in care.
- Women evaluated the service highly.

- The conservative indications were that the service was cost neutral and likely to be cost effective.

Contrary to expectations, the findings from the follow-on study suggested that the differences associated with the pilot scheme increased over time. By the standard assessment measures utilised the project had proved 'successful' on both evaluations.

The Thesis

This thesis is drawn from the descriptive arm of the evaluation that focused on the organisational change and its meaning for professionals. The way in which the study was undertaken and the reasons behind the choices made concerning the research approach, practice, analysis and reporting of this work are discussed in chapter two.

Although a physiological process, childbirth is a major life-changing event that is culturally constructed (Kitzinger, 1989), such constructs are not static but alter over time. In understanding how radical a change was involved in the implementation of caseload midwifery, and why this was considered necessary within the English maternity service, chapter three considers the influences which impacted on childbirth in England during the past century. This places the study in the context of wider social and political developments influencing the nature of childbirth, and the position of those who attend it, at the end of the 20th century. It also offers an explanation as to why the nature of the work of British birth attendants is currently so very different from those who practised or practice in a different time or place.

The environment in which a change is planned and the manner in which it is implemented will dictate the nature of the change proposed and affect the way individuals respond to it. Ultimately such factors affect the way the change is 'allowed' to develop and the experiences of those involved in it. Acknowledgement and accounting for these factors is integral to ethnographic research, in contrast to more positivist approaches which hold an inherent assumption that the model will be the same and generate the same effects wherever or however practised. This is a drawback of many of the evaluations of new midwifery practices that have taken place.

Chapters four and five address these 'context' issues by providing a 'thick description' (Geertz, 1973) of the maternity service in which caseload practice was implemented.

Consideration of the planning and implementation phase and outline of how the scheme was operationalised by the caseload midwives is followed by an overview of the reactions of the midwives and obstetricians working in the parallel conventional service. Such issues are important in determining and understanding the supportive and undermining influences on the project development. Also, an understanding of the environment in which the caseload practitioners had previously practised aids an appreciation of the changes involved in assuming responsibility for a caseload

The subsequent five chapters consider the nature of caseload practice as experienced by the thirty-five caseload midwives who participated in the study. In undertaking caseload practice these midwives found they were expected to practice in a very different way and a steep 'learning curve' was acknowledged by them all. However, the differences involved more than the tangible, clinical issues inherent in the requirement to apply all midwifery skills to a variety of individuals and situations on a daily basis. The midwives found they needed to make radical alterations to the way they conceived of midwifery and their role as a midwife, the intra- and inter-professional relationships that were integral to their work, and the way they viewed and handled their lives. Learning to become a caseload midwife forms the focus of chapter six.

Despite the enormous change experienced, once they had settled into the work the midwives found it immensely satisfying; the sources of this are explored in chapter seven.

An ethnography undertaken over 46 months generated a lot of data and a variety of perspectives on the subject studied. The choices made for the focus of this thesis reflect the particular value of the ethnographic approach and duration of this study. The themes explored offer perspectives that may not have emerged so clearly from alternative approaches, yet were identified here as being fundamental to the nature of caseload midwifery. Issues concerning the 'self' of the midwife and reciprocity in the relationship formed with mothers, concerning power and the development of a new form of professionalisation, and concerning the different ways the midwives needed to conceive of, and use, their time are considered in chapters eight, nine and ten respectively.

These choices were made in recognition of a number of other areas that could have fruitfully been addressed; areas such as change management, theories of oppressed

groups, and in particular, important perspectives on the education of midwives. The data collected relating to these areas can be used to inform such debates in future publications.

Studies from other models of midwifery implemented in response to *Changing Childbirth* have suggested that many continuity of care and carer schemes present particular difficulties to midwives and are not sustainable in the long term. However, these studies have commonly been undertaken on relatively short-term pilot schemes, and thus reflect a particular stage in the implementation of the model. They also examine a wide range of, often poorly defined, models of practice. This study offers consideration of a longer duration where the initial 'teething problems' have been worked through and issues concerning sustainability may be more clearly identified. The findings are considered in relation to the alternative studies and, it will be argued, are suggestive that for some midwives caseload midwifery offers a more sustainable model of practice.

The implications of these findings for the maternity service are addressed in the concluding chapter.

Conventions used in the text

Two conventions have been adopted within this thesis. The first is the use of the term 'mother'. This acknowledges that conception instigates a biological and psychological motherhood, pregnancy being the liminal phase towards physical and social motherhood. The majority of literature denies this early form of motherhood, although such denial may not to be assumed by women themselves.

Midwives used a variety of terms; hospital midwives tended to use 'patient' or 'woman', whilst community and caseload midwives used 'woman', 'client', 'mother' or the individual's given name. No term appeared dominant so the term 'mother' has been adopted throughout the thesis to avoid confusion by the term 'woman' referring to either midwife or mother.

The second convention is the use of gender-neutral terms to maintain a degree of anonymity. This is used in recognition that only one male caseload midwife and two male student midwives, and one female senior obstetrician participated.

The issue of gender did not arise as a main focus of this study although there are clearly considerations when male midwives carry a caseload. Apart from indicating that a male midwife can successfully carry a caseload, the experiences of one individual cannot usefully inform an understanding of such practice. Data from this source has, therefore, not been treated separately but used to inform the general analysis.

A gender-neutral stance has been taken where possible; where this appears inappropriate the dominant gender of the occupational category has been assumed, rather than indicating the actual gender of the participant.

Clarification of terms

A glossary is provided after the appendices for readers unfamiliar with terms used in this thesis. However, concepts relevant to the description are defined at this juncture as these proved key terms.

Continuity of carer

One midwife is responsible for supervising midwifery care to a mother throughout her childbearing experience. Although not necessarily providing all that care herself, for example when a mother is admitted to hospital, she remains closely involved with, and aware of, all care provision. Thus continuity of both care and carer is achieved as far as realistically possible.

Caseload

One midwife is responsible for the midwifery care of 40 women per year, assisting the mother before, during and after delivery, wherever necessary. Thus they are able to establish a close relationship with their clients and get to 'know' the mother and her family well. Although the midwife's partner or, occasionally, group colleagues may assist with providing care, the individual is the 'named midwife' for particular women. This is termed 'partnership' caseload practice elsewhere (Walsh, 1999).

Integrated

Care is undertaken in both community and hospital by the same provider. In this project the caseload midwife visited the mother at home and accompanied her into hospital if required, providing a 'seamless service'. Caseload practitioners worked

wherever the needs and choice of their mothers dictated, moving freely between home, GP surgery, hospital clinic, delivery unit, and ward.

'All care'

One midwife cannot provide all midwifery care for each woman. Unplanned events such as premature labour, admissions to hospital where 24hour cover is necessary, and prolonged labour mitigate against this, however carefully organised or dedicated the midwife might be. The expectation in the project was for caseload practitioners to provide care where possible, appropriate and safe to do so. The partnership and group arrangement was designed to facilitate colleague support and cover for midwives' social lives and leave arrangements. Immediate care of women admitted to hospital was the responsibility of the hospital midwives on duty. However, elements of care were then undertaken by the caseload practitioner where reasonable, and were negotiated between the midwives on a situational basis.

'On call'

Conflicting definitions of 'on call' for caseload midwives have generated the greatest confusion, both in the literature and at the study site. For many health professionals 'on call' refers to 'being available to work' if needed, frequently in addition to a standard day's work, but not working unless called. Hospital doctors and community midwives routinely undertake 'on call' cover at night, weekends and bank holidays. The general expectation is that they will be called and need to attend - if in the community, to the home of a mother they are unlikely to know. 'On call' in this situation is equated with being disturbed. Practitioners commonly have to work the next day with minimal rest to compensate for the disturbed night. Extra payment allowances are provided for 'on-call' cover, with additional payments for the period called out.

In contrast, 'on call' for these caseload midwives involved 'being available' for mothers on their or their partner's caseload; very occasionally they needed to cover for other members of their group. In this situation the midwives would usually know the mother who was calling and could respond appropriately without necessarily visiting her. Caseload midwives did not work 'set' hours and were not tied by fixtures such as running clinics, but planned their days around the needs of their women. Thus, when called out, they could alter their workload the next day accordingly. Caseload midwives were not used as a reserve workforce for the hospital, to be called in if the unit was busy.

To help avoid confusion, the term 'availability' rather than 'on call' was suggested for caseload practice - but its use was not generally adopted. Nevertheless, in this thesis 'availability' rather than 'on call' will be used when referring to the caseload midwives to avoid misunderstanding.

Chapter 2

STUDY DESIGN AND METHODS

This chapter considers the way in which the study was addressed. In line with the fundamental reflexivity of ethnography (Hammersley and Atkinson, 1983) this section will be presented in a reflective manner which defines both the intent and the experience of the study. The advantages of the approach used and the way in which the disadvantages were tackled are discussed, and the manner in which the data were generated and analysed described

Aims and objectives

The study from which this thesis is drawn was originally one arm of the evaluation of caseload midwifery described in the previous chapter. This service development was a direct response to the change in political thinking concerning the delivery of maternity care, initiated in the Winterton Report (1992), outlined in *Changing Childbirth* (DoH, 1993) and culminating in the NHS Executive Directive in January 1994 (see chapter 3).

The new policy was aimed at improving care delivery and the experience of childbirth for women in response to concerns about the increasing medicalisation of childbirth and the growing body of evidence that suggested the positive effects of feeling in control, being offered choices, and continuity of carer had for women (Oakley, 1992; Reid and Garcia, 1989; Green *et al*, 1988). However, whilst giving women choice, continuity and control were espoused as the ideals, the significance this held for professionals was not well understood. The organisational and political changes required, and the tensions that might be generated for them as individuals were acknowledged but not clarified. Also, the radical new form of practice studied here had obvious implications in terms of place, style and timing of work for caseload midwives. Being introduced at a time when junior doctors hours were being decreased suggested a contradiction in thinking. Midwives' willingness and ability to work with a caseload were questioned, as were the effects this change in practice might have on those who elected to remain delivering the conventional style of care.

The aim of this study was to address some of these issues by exploring the implications of the implementation and subsequent development of caseload midwifery in one maternity service from the perspective of the midwives and obstetricians involved.

The objectives of the study were:

- to gain an understanding of what it was like to work as a caseload midwife within the NHS, identifying strengths and weakness of this style of practice, and consider issues of sustainability,
- to identify the implications of this service development for the midwives and obstetricians who continued to deliver conventional care.

For pragmatic reasons, this study did not include exploring the reactions and perceptions of General Practitioners (GPs); there were more than 50 GPs working in the study area and no resources were available to extend the study this wide. This omission held minimal implications for this thesis, which focuses on the practice of caseload midwifery.

Study design

The study was undertaken using an ethnographic approach.

Ethnography: seeking the emic perspective

The use of ethnography in research has a long history stemming from early anthropological studies of 'native' communities. However, it has since been used in multiple ways so that definitions of ethnography have become confused. Indeed the term may now be applied to a particular philosophical paradigm, a method to be used as and when appropriate (Atkinson and Hammersley, 1994), or even the product of such inquiry (Agar, 1980).

Hammersley and Atkinson (1983:1) noted disagreement amongst proponents of ethnography about its distinctive features, highlighting a variety of approaches from Spradley's (1980) *'elicitation' of cultural knowledge*, Gumperz's (1981) *identification of patterns of social interaction*, Lutz's (1981) *holistic analysis of societies* and Walker's (1981) *story-telling*, to the more theoretical orientations of Denzin (1978) or Glaser and Strauss (1967). Recently, the ethnography which has become popular within nursing

studies, uses a more particularistic focus in addressing specific issues (Muecke, 1994) as a pragmatic response to limited resources and time constraints.

The use of ethnography within the wider evaluation was originally conceived in this latter sense, with a focus on the implications and change process. However, the study was actually undertaken utilising a more traditional anthropological approach of 'total immersion' in the study field and a conception of ethnography similar to that later offered by Atkinson and Hammersley (1994). This featured:

- A strong emphasis on exploring the nature of particular social phenomena.
- Working primarily with 'unstructured' data, i.e. data that have not been coded at the point of collection in terms of a closed set of analytic categories.
- Investigating in detail a small number of cases, perhaps just one case.
- Analysis of data that involves explicit interpretation of the meanings and functions of human action, the product of which mainly takes the form of verbal descriptions and explanations.

(Atkinson and Hammersley, 1994, p.248)

Ethnography is based on the epistemological assumption that there are multiple realities and perspectives on our understanding of the world, and it seeks to provide an interpretative understanding of these (*verstehen*, Weber, 1949). The underlying principles of naturalistic enquiry, understanding and discovery (a heuristic approach) which are fundamental to the approach (Hammersley, 1992), were considered appropriate to a study of a 'naturally occurring' phenomenon, a change in midwifery practice, in which the implications were unknown and were likely to be different for different people.

The ethnographic approach has been considered particularly helpful in organisational studies that, in seeking to understand a social situation from the perspective of those involved in it, emphasise "*individuals' interpretation of their environment and of their own and others' behaviour*" Bryman (1989:29). In focusing on individuals' perspectives, the differences in significance that people accorded to particular issues can be explored. In particular, the perspectives of the less powerful are acknowledged, a group whose views, as Bryman (1989) noted, are rarely highlighted although

organisational changes may hold serious implications for them. In the highly hierarchical organisation of a hospital service, this approach facilitated consideration of the views of junior staff and students as well as the more powerful managers and consultants.

The centrality of an appreciation of the participant's perspective on the situation studied in ethnography may be summarised in the etic:emic distinction. Derived from the linguistic work of Pike (1967), emic analyses stress the subjective meanings shared by the social group whilst etic analyses refer to the development and application of ideas derived from an external view, commonly the researcher's (Seymour-Smith, 1986). Although the actual distinction is less clear cut than such definitions suggest (see Morse, 1994:158 for a succinct resumé), in seeking an understanding from the perspective of the participants, ethnography does not involve the imposition of pre-determined ideas or theoretical models. Thus, extensive reference to the literature was made to facilitate an understanding in the analysis of data collected rather than informing the collection of that data.

Detailed understanding of the 'emic' situation, as opposed to 'individual meanings', necessitates the use of a variety of methods of data collection, facilitating a more rounded understanding of 'what is going on'. Such triangulation of data collection (Denzin, 1978) helps strengthen the understanding gained by avoiding bias from time-specific incidents or particular individuals. In this study participation, observation, interviews and survey questionnaires were all used to assist with generating a robust understanding of the meaning and implications of caseload midwifery. The manner in which these methods were adopted will be discussed below.

Aiming to provide an authentic representation of a naturally occurring setting, whilst recognising the social continuity and complexity of the situation, and proving meaningful to the people being studied, ethnography utilises an inductive style of analysis (May, 1993) to generate 'thick descriptions' (Geertz, 1973) of the situation. Generalisations are made to typologies (i.e. at a theoretical level) rather than populations (Hammersley, 1992) and so inform rather than determine knowledge in the given area. This study of caseload midwifery, although initiated to inform the local service development, offers theoretical perspectives that contribute to an understanding of caseload practice *per se* that can be used to inform service developments elsewhere (Mitchell, 1983).

On recruitment to carry out the ethnographic arm of the evaluation, acceptance of the study in principle had already been negotiated (Evaluation Protocol: Page *et al*, 1994). The continuation and development of the ethnography beyond the initial two year pilot period was recognised as offering important data concerning the experiences and perceptions of working in a more honed service than the initial project implementation period allowed. Thus this study of caseload midwifery constituted what Mitchell defined as "*an extended case study*" (1983:193). The collection of data over 46 months enabled the processual aspect of the innovation to be emphasised, reflecting changes and adjustments over time as well as simple patterns of relationships.

Ethnography was used in this study to make explicit that which was implicit in the experiences of the midwives by studying them in their 'natural setting' at work, seeking to achieve a valid understanding of what was 'going on'.

Construct or reality: subjectivity in research

One of the central criticisms of ethnography concerns the subjectivity of the research process, a perspective that considers the focus of the work, data collected, and analyses undertaken to be invariably biased by the researcher. This contrasts with alternative epistemologies which contain an inherent denial of the person of the researcher. The emphasis is placed on the neutral, impersonal and scientific nature of the work and the act of researching is viewed in a mechanistic sense; published work is depersonalised with the writer emphasising objectivity and value-free statements. This perspective is premised on the assumption that there is a 'reality' which exists independently of our experience of it and that this can be 'captured' by the correct research approach (Reed & Boitt, 1995), a debate which is central to the philosophy of science.

However, this argument ignores the fundamental social context and involvement inherent in all research processes. Rather than being empirically collected from an external, objective world, data are ecologically (place and time) and politically context specific, and their collection is a process in which the researcher is inextricably embedded. In ethnography, particular consideration of this situation enables the "weakness" to become a strength, enhancing rather than contaminating knowledge development.

Relationships and the research process

Acknowledgement rather than denial of the position of the researcher has long been pleaded, and consideration of their possible influence on the research process recognised as an important part of the analyses (Garfinkel, 1967). More recently, consideration of the individuality of the researcher and the centrality this may play has been emphasized by Okely (1992) and Cohen (1994). In much qualitative research, the personal skills of the researcher are fundamental to the research process; the manner in which they handle themselves and relationships formed with the study participants inhibit or encourage data collection and subsequent understanding of the situation being studied. As Okely (1992) noted, participants relate to a person and to the characteristics they have ascribed to them, whether or not the ethnographer acknowledges this. It is the person of the researcher that others confront, receive and confide in; a situation that, it could be argued, is not confined to qualitative research when considering the issues of recruitment, retention and compliance in trials, for example.

Familiarity with the study setting or community, as experienced by practitioner-researchers, may prove helpful in achieving fruitful relationships but is a situation which holds dangers of additional subjectivity as well as difficulty in 'seeing' what is familiar.

Practitioner-research

Ethnographies undertaken by researchers who are also members of the community being studied have been conducted in professional organisations such as education and the police force, as well as the health services. When research is undertaken by someone who is familiar with the setting, their tacit knowledge (Polanyi, 1967) of that community is recognised as proving an invaluable aid in controlling their effect on the study situation, and in facilitating effective communication with the study participants (Meerabeau, 1992). In some situations it may prove essential; for example, the Police Force where a deeply ingrained distrust of social scientists predominated (Young, 1991), and strategies to exclude the uninformed researcher were adopted that undermined the research (McCabe and Sutcliffe, 1978).

However, practitioner-research has been viewed with scepticism, being thought to entail an inherent subjectivity with the researcher being unable to theoretically disentangle themselves from their work (Field, 1991). Also, maintaining research awareness within a familiar setting and not inadvertently imposing their own 'world view' on the setting, are inherent difficulties which demand constant reflexivity from the ethnographer. Nevertheless, Hammersley (1992) pointed out that the self-knowledge demanded of all ethnographers is not immediately given, and that people can deceive themselves and may have an interest in self-deception. This warning is particularly pertinent for practitioners who have both a history and a future in their profession (Reed and Proctor, 1995). Their knowledge about the wider context of the study may be extremely detailed but they will invariably carry value judgements and expectations concerning practice and the development of the profession. Such values need to be acknowledged and accounted for in order to help avoid the perception, as well as reality, of bias.

An advantage for practitioner-researchers in health care is that the social skills Okely (1992) advocated may already be honed for, as Lipson (1991) noted, although the goals of nursing and of research are different, the skills and qualities that enhance rapport and trust are similar; a situation in midwifery recognised by both Kirkham (1989) and Hunt (Hunt and Symonds, 1995). Lipson (1991) re-emphasised that the best data grow out of relationships in which the informants trust the researcher, and in which the researcher has a grasp of their own influence on the interaction. However, the experience, skill and maturity of the researcher are considered fundamental.

Another potential advantage for practitioner-researchers was highlighted by Cohen (1994) when he accused anthropologists of "*ethnographic myopia*". By ignoring the individuality of researcher and researched, Cohen suggests, *anthropologists "inevitably perpetrate fictions in our descriptions of other people"* (Cohen, 1994). Quoting Naipaul in stating that "*the only way we have of understanding another man's condition is through ourselves, our experiences and emotions*", Cohen (1994) argued the importance of both the acknowledgement and analysis of the researcher's self through reflexivity. By addressing the question "*what would this mean to me?*" he considered the researcher would be led with a greater sensitivity, to consider "*what would it mean to them?*". This argument was particularly pertinent to my work when undertaking clinical practice within the organisation I was studying. Although not undertaken as a means of formal data collection, personal experiences proved an important part of the 'immersion' process, assisting greatly with my

understanding of the culture of the organisation and sensitising me to questioning other practitioners' views and responses.

Biography of an "insider"

In acknowledging the potential benefits of undertaking research within one's own profession, it is equally important to identify the possible disadvantages in order to counteract potential bias and ensure quality of data collection and analyses. Thus it was important that early in the study I determined my personal position in relation to the work I was undertaking, identifying the strengths and weakness that I was bringing to the research.

Eighteen years experience as a practising midwife meant I was an 'insider' to the maternity services, familiar with the setting, jargon and expected behaviour. However, frequent movements and ten years overseas experience, working with and for people who held very different views to myself, had forced me to confront my own views, assumptions and training. These experiences proved central in achieving the "*anthropologically strange*" stance advised by Hammersley and Atkinson (1983:8). With appropriate supervision, the criteria recommended by Lipson (1991) was fulfilled: that research within one's own culture should only be undertaken by someone who has 'gone outside it first', had experience in various settings, is extremely self aware, and has a good mentor to bounce things off at all times.

My personal interests lay in the nature of birth and those involved in assisting it. Having worked for a number of years with Traditional Birth Attendants, whom I considered had taught me 'midwifery', I was deeply concerned about the nature of 'midwifery' practised in England. *Changing Childbirth* (DoH, 1993) appeared to present an exciting development for maternity services; nevertheless, I had some serious questions concerning the consequences it held for midwives. The nature of traditional birth attendant work in 'traditional' communities presented positive images; however transplantation of these ideals to a post-modern society could generate unexpected complications, not least for the midwives concerned. Having recently completed a first degree in social anthropology, I was interested in using such perspectives to explore this situation.

I had never previously worked at the study site, and not being involved with the planning and administration of the innovation, I was an "outsider" in terms of the hospital staff and the project, unknown to all except my senior manager when I first arrived.

Assessment of the "insider" perspective

Constant reflection on the effect being an 'insider' (in professional terms) had on the work was imperative and formed a central part of the preliminary analysis of data collected. The main points are summarised below, considering the issues of access, field-roles, and data collection and analysis.

Access

Formal access to the study setting and to individuals had been negotiated as part of the evaluation protocol prior to my arrival and through the process of a job interview and selection. However, in ethnography access to data needs to be constantly renegotiated at all levels. In this, an understanding of the nature of the organisational 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.

Field roles

Previous midwifery experience, and subsequent "*ascribed characteristics*" (Okely, 1992), made it difficult to play the 'acceptable incompetent' advised by anthropologists. Nevertheless, in the construction of a working identity it proved easy to follow Hammersley's (1992) suggestion to exploit one's relevant skills and knowledge. It is the anthropologist's desire to be accepted as one of the community so the study setting can be observed in as natural and undisturbed manner as possible. Appropriate modification of dress, behaviour, and language facilitated an easy blend into the hospital environment; I sensed I quickly became accepted as member of staff, albeit probably not a proven or trusted member. That this was achieved with ease, and did not cause a strain, was both personally beneficial and encouraged participants to respond in an equally relaxed manner.

When a clinical role was assumed it was as an E grade midwife; without status or managerial responsibility this was considered more appropriate to facilitate an understanding of the situation of the majority of hospital midwives. The potential for professional and research conflicts of interest were acknowledged and discussed with the hospital midwifery manager; it was agreed when acting as a clinical midwife, women came first, the research second. Such conflict never actually arose.

The ability to work as a clinical midwife within the context of the study setting proved helpful, particularly with uncovering information and ideas, and facilitating the capacity to empathise with staff and reflect on personal responses to working in that setting. An understanding about the nature of the work was gained from working alongside participants; this helped to uncover embedded knowledge which may not otherwise have emerged (Okely, 1992). Cohen (1994) exhorted anthropologists to examine their own reactions as this may sensitise them to the view of others. So an acknowledgement of my own depressed reactions when working on a postnatal ward, or feelings of utter exhaustion after a busy shift led me to question how other midwives reacted in such situations. Discussing this with them involved a sharing and exploration of ideas rather than a one-way tapping of information.

Occasionally some passing comment made during a shift stimulated a new way of thinking about things. For example, when chatting about the particular demands of the delivery unit, a colleague observed that *"we work to a minute time-frame up here but on the wards it is in hours"*. The use of time proved an important theme in the analysis, but that particular aspect of it had not arisen. It was fruitful because it could be related to immediately and the ideas 'bounced' around with colleagues during a coffee break.

Data Collection and Analysis

Data collection and analysis are not separate activities in ethnography but build on each other in an iterative process. Both were positively influenced by the "insider" perspective. In the collection of data, an understanding of hospital organisations proved helpful in:

- liaison with the management to promote as sense of transparency rather than secrecy, in the way individuals were approached, the appropriate timing for meeting people, and helping to put individuals at ease to create an atmosphere which facilitated discussion. The use of language is particularly powerful and the ability to communicate in the argot of ones' own profession (Spradley, 1979), using jargon to express commonality, helped to create a relaxed non-threatening environment.
- defining appropriate ways of collecting 'accurate' data. An understanding of the various strategies people used, and of the possible ways they think and act, was helpful in identifying what could affect the collection of data. For example, in trying to assess the reality of hospital midwives' input into caseload midwives' cases (they reported it as being high), the use of the clinical records as an accurate reflection on

care given were quickly rejected. Clinical records are documentary constructs that are created for particular purposes (Scott, 1990); they are not full representations of reality. The recognition of 'hidden agendas' reflected in such constructs was easier for an 'insider' researcher with knowledge of what was generally the 'norm'.

- assessing information. At a certain level, an understanding of what people were talking about proved helpful in interviews, by facilitating an ongoing assessment, mentally questioning whether it 'sounds right' as a form of face-validity check. Something which sounded unusual could then be explored further. However, this process could be dangerous as it involved an implicit imposition of personal judgement about what was "normal". Also, trying to avoid such bias by asking for clarification to ensure an understanding of the interviewee's view could generate irritation. By denying the commonality previously established, the carefully developed atmosphere was occasionally ruined.

Strategies for minimising the problems inherent in practitioner-research

Despite the many advantages of the "insider" perspective, there are some fundamental problem areas. Cohen (1994) noted how the existence of common understandings and meanings among even closely knit groups should not be taken for granted. Not only was there the danger of imposing a personal 'world view' on the data generated, but the potential for a wide variety of meanings had to be acknowledged and accommodated. Also, whilst tacit knowledge of the field simplified working in it, that implicit knowledge needed to be made explicit and accounted for in the analysis.

Strategies that were found helpful included:

- 1) The use of tapes during interviews. Subsequent analysis of the transcripts enabled identification of leading questions, issues that were not clarified, and hidden assumptions. For example, the transcription of a meeting which appeared to have gone well and generated fruitful data revealed that the discussion consisted of mainly half finished sentences; communication had been easy and in some depth but not in a form that facilitated subsequent analysis. It was a useful lesson. Such deficiencies cannot be corrected, but they can be compensated for during further data collection, and avoided in future.

- 2) Geographical distance between study site and analysis site. Living on the study site during the week, the physical movement between fieldwork and home most weekends paralleled and facilitated a mental movement from practical to theoretical orientation. This enabled a 'standing back' and more objective consideration of the work.
- 3) Reference to an academic community and close contact with 'outsider' supervision. One of the problems of working within one's own profession is the development of a rather parochial view. However, working with an anthropologist involved with the evaluation and a university supervisor, neither of whom were clinically trained, proved invaluable in identifying assumptions, challenging ideas and assisting with new ways of looking at the situation. Also, stimulation and fresh ways of viewing the material were gained from mixing with other researchers at seminars and conferences, and through informal networks.

Receptivity and reciprocity

Participants' receptivity to the study holds important consequences for the quality of data collected and the valuation placed on the findings; negative reactions seriously undermining the acceptability of the completed work. However skilled the ethnographer, it would be difficult to obtain quality data from participants who, for whatever reason, were un-supportive of the study.

In ethnography, Hammersely & Atkinson (1983) cautioned that research participants are usually more interested in how far the researcher can be trusted, what they might be able to offer, and how easily they can be manipulated or exploited, than the actual research itself. In this study it was likely that participants would have concerns about positive or negative publicity for the unit or themselves. Such 'hidden agendas', however subconsciously held, could bias the study of such a high profile implementation.

Recognising that ethnography is not valued highly by some senior health services professionals who consider it time consuming and not providing the definitive answers commonly desired, and that this study would probably be viewed as the least important part of the evaluation, it was particularly important to encourage a positive response. Strategies used included a particular sensitivity in the approach adopted, an awareness of the 'demands' made on busy schedules, and a careful selection of initial respondents,

targeting those recognised as being sympathetic to the evaluation in the hope they would report positively to their colleagues.

Learning from experience by careful reflection on the participants' reactions, to minimise possible future negative reactions, and identifying biases that may skew the analyses formed important elements of the reflexivity of the ethnography. The positive responses and occasionally overwhelming amount of data individuals gave was thought provoking. Reflection on the responses of the different groups is summarised as follows:

Caseload midwives:

Participation in the research was a requirement for the caseload practitioners, included in their job description. The original twenty were highly motivated, aware of the political importance of the project and, in theory, positive towards the wider evaluation. However, with the initial demands made on them this proved to be just an added burden. Nevertheless, their participation in the ethnography appeared welcomed, proving a channel to vent their feelings in a relatively safe manner. They had accepted the challenge of caseload practice but it was important that their perspectives on the work were recognised; this part of the evaluation demonstrated concern for them as individuals, not just midwives.

Midwives working in the conventional services:

None of the midwives working in other services refused to participate, and several gave lengthy and informative interviews. However, a sense was gained that the ethnography was viewed as being biased towards caseload practice; as 'part of the project' the evaluation and caseload service were viewed synonymously. An attempt to counteract this view was made by undertaking clinical practice within the hospitals; this facilitated an understanding of the local culture of midwifery and the ability to adopt an empathetic attitude towards the hospital midwives' situation.

Managers:

All the managers made time to participate and offered useful perspectives on the situation. The danger of those involved with the implementation of the caseload project having an investment in the service development and so offering a particular slant on the situation was recognised. However, analysis of these interviews suggested open discussions about their hopes and fears concerning the project.

Medical Staff:

Despite an initial concern, all invited medical staff participated in the research with only one consultant clearly reluctant to discuss their views in any depth. An approach in terms of 'lessons to be learnt' appeared an acceptable objective to all doctors. Several of the experienced researchers posed probing questions concerning the methodology, others expressed feeling intrigued by it. Those seriously interested in the project gave considered responses, and appeared to value the time of enforced reflection on the change implemented. Several of the senior medical staff noted how reassured they felt that a comprehensive evaluation was integral to the implementation of caseload midwifery.

Reciprocity within ethnography

Hammersely & Atkinson's (1983) warning about being used, being seen as a source of 'insider' knowledge proved to be unfounded in this study. Analysis of the transcripts highlighted few instances where information was sought by the participants. However, the apparent openness with which many individuals talked was unexpected, and several warmly thanked me for the meeting. In reflecting on what value the meetings might hold for the participants two issues were highlighted:

- Firstly: making oneself available at an unsocial hour and offering focused attention to individual's views, demonstrated a respect for them personally, a situation not so frequently experienced by junior members of the health service staff.
- Secondly: the interviews forced people to reflect on their situation and to consider issues in a way that their busy schedules often prevented. The probing questions proved helpful in enabling individuals to focus more clearly on their situation, to offer a vent for their frustrations and a channel for their views. Many people appeared to find the talks helpful and in this way the ethnographic interview proved an aid to the change process.

The realisation that the interview appeared particularly helpful to some of the respondents proved a positive counterbalance to the potentially parasitic nature of some ethnographic research (Lipson, 1994). An element of reciprocity was also achieved by my acting as a resource for the midwives in responding to queries concerning general

research issues, information, ideas for references or advice concerning questionnaires, usually whilst grasping a quick coffee when undertaking clinical practice on the unit. Such reciprocity was also important for the directorate managers and, responsive to their needs, requests for specific feedback that required a particular analysis to be undertaken were met.

Ethical Considerations

Value

The most fundamental question for all research concerns its value and contribution to new knowledge, it being unethical to waste limited resources in unnecessary research, the use of inappropriate methods, or the work of poorly suited or unsupported researchers.

The requirement to assess any major changes in a service delivery to ensure the change improves care does not necessarily consider the effect on the care providers. However, the change implemented in this situation was so radical that to ignore the implications for professionals could have been considered unethical.

Continuation of the study beyond the originally envisaged two-year evaluation enabled it to address questions concerning longer-term effects and sustainability, and the nature of the service once the initial implementation problems had settled. This was considered highly relevant to the current debates concerning midwifery and maternity service developments.

Access approval

Initially, ethics approval for the complete evaluation was sought and obtained from the hospital Research Ethics Committee (REC), in line with the NHS Executive requirement. Once determined that the ethnographic study would continue beyond the two years evaluation, clarification concerning subsequent approval was sought and considered unnecessary providing clients were not approached. (see appendix 1, letter from the Secretary of the Research Committee) The acceptability of accompanying midwives on their visits, which would necessitate contact with mothers, was confirmed on the understanding the women would not be used as research participants (telephone discussion and personal meeting with REC Secretary).

This situation reflected the remit of the REC at that time in acting to protect hospital clients but being less focused on the rights of hospital employees, considering them perhaps, powerful enough to refuse participation. Nevertheless, the potential for the exploitation of any participant is present in all research and relates just as much to the professionals offering care as those receiving it.

The midwives interviewed for the project positions were made well aware of their integral involvement in the research and obstetricians were confident enough to refuse to participate in midwifery-related studies. However, the reality of more junior staff, particularly student midwives, being a 'captive audience' and reluctant to refuse for fear of stigma or repercussions on their career could not be overlooked. I recognised a duty to protect, and ensure participants felt protected from negative consequences of their co-operation with my work.

Although approval to work with staff had been granted by managers at the start of the evaluation, permission to work with particular groups was sought from the relevant managers at each stage of the research. This was both a courtesy and a strategy for allaying concerns about working 'behind people's backs'.

Field roles and the overt-covert dilemma for the practitioner-researcher

In negotiating access to the research area, practitioner-researchers may be faced with an ethical dilemma as they define their field roles. Individuals' response to the researcher will depend on the characteristics they ascribe to them, a situation which has the potential for biasing the data. It may be impossible for experienced practitioners to adopt the naive stance recommended by Hammersley and Atkinson (1983); however, deception offers little to relationships based on trust.

Covert research is rarely considered appropriate, nevertheless, some practitioner-researchers report being economical with the truth: Ersser (1996) found his youthful appearance enabled him to avoid disclosure of his Tutor status when working as a Research Nurse. Alternatively, researchers may emphasise various aspects of their biography depending on the situation. To other practitioners Ersser found he was

considered as a researcher who was also a nurse, whilst to patients he was a nurse doing research.

Considering it not to be true deception, this form of "*impression management*" (Goffman, 1959) proved a helpful strategy when working with groups who were not familiar with my work; thus to the obstetricians an emphasis was placed on my academic background, to midwives my midwifery orientation without stressing a level of experience. When undertaking clinical practice, extensive overseas experience resulted in genuine unfamiliarity with many aspects of current service delivery – a situation that was played on by asking questions and requesting help. This enabled the presentation of a less threatening persona and the ability to gain a deeper understanding of the situation from the practitioners' perspective.

In the clinical field people occasionally mixed my roles on purpose; for example, acknowledging that although not on the unit working as a researcher, a sister called me to see a mess left by one of the caseload midwives. This undoubtedly worked to my advantage and such 'role swapping' was encouraged when instigated by the participants.

Nevertheless, as familiarity developed people forgot my research role and related to me as a trusted colleague. Although such "*porous boundaries*" (Lipson, 1994) were highly desirable in terms of minimising impact on the study setting, the tension between being so relaxed and enabling people to confide as a friend rather than a researcher and yet conducting ethical research was clearly apparent.

In general, I considered it unethical to use information learnt from individuals who appeared to confide in me as a colleague they felt they could trust and unburden to. However, if particularly insightful issues arose permission was asked to note down points for the research. If this was refused or it appeared inappropriate to request consent, what had been learnt could not be forgotten, but such conversations were used as sensitising to things that could later be explored as a general rather than particular issue.

Considerations during the process of the study

As well as the initial considerations, several ethical issues are fundamental to the process of the study. General points include the way in which participants are approached and decisions relating to the place and timing of data collection as concerns about coercion and any potential impact on service delivery need to be addressed. Problems in these areas can be minimised by the practitioner-researcher's knowledge of the situation. However, two major considerations are more involved, that of consent and confidentiality.

Consent

Central to all ethical research is the requirement that all participants provide 'informed consent' before participation, and that they are subsequently free to withdraw from the study at any stage without repercussion. Although apparently straightforward, these principles prove more problematic in practice as consent is not a one-off event, there being many layers to each situation.

In general, 'major' respondents were sent a letter outlining the work, requesting co-operation and providing contact details (appendix 3); wherever possible, arrangements for the meeting were made by personal contact. Before starting the interview, an outline of the work proposals and methods was offered with as much information as appropriate or requested. At every stage the possibility of withdrawal was indicated.

Participation in observational data collection was more complicated as this invariably involved a number of people who would be observed but not included in data collection, e.g. mothers. However, consent was always sought in a manner that facilitated refusal. For example, when planning to observe working practices, the midwives sought the consent of the mothers they were caring for, or obtained consent for me to approach them. This enabled either midwife or mother to refuse without clear identification of who was declining to participate.

When data were obtained by less formal means, such as serendipitous 'corridor chats', permission to use points raised in the conversation was requested and, if granted, notes made immediately after the event.

Although only a few women, and no member of staff, refused to participate, the pressure to be seen to be co-operative might be influencing behaviour. However, their presence or absence from arranged focus group meetings, their degree of participation, and the non-return of questionnaires were forms of non-co-operation that were respected. In the few instances where midwives did not return a questionnaire or arrange the requested exit interview, two reminders were sent but the issue was not pursued further.

For consent to be valid it is important that "*all pertinent aspects of what is to occur and what might occur are disclosed to the subject*" (Homan, 1991:71). However desirable, truly 'informed consent' was impossible to achieve. Although many participants were not interested in full explanations, for those who did engage in the issues, the full disclosures directed by Homan (1991) could not be provided. Ethnographic studies involve a dynamic process in which the focus may develop and alter radically as the work progresses. If the researcher is not sure exactly how the study will develop at what stage can fully informed consent be sought? Recognising the work would develop on from a study of the implementation, consent was negotiated on a relatively broad basis. However, in retrospect, a 'process of consent' as described by Munhall (1991) would have been more appropriate.

Truly informed consent also requires that the participant be made aware of any potential negative effects; in view of the political sensitivity of this study, 'negative' findings held the potential for damage to the reputation of both individuals and the unit. Although unable to define these at the point of consent, issues from the initial and subsequent analyses were fed back into the project area as the work progressed, so no 'unexpected' disclosures were likely to be presented in the final analyses.

Confidentiality

The assurance of confidentiality through anonymity is a central tenant of ethical research. It is hoped that participants will respond more openly and honestly if they cannot be identified from the data or harmed by the views expressed becoming public knowledge. In this study issues of confidentiality arose at two levels: in obtaining and handling the primary data, and then making public the findings.

Data control

Maintaining the anonymity of individuals was critical as the potential for damage was very real; both my and my participant's reputations were at stake. Where possible, interviews were conducted away from the hospital site, otherwise they were held in private rooms to avoid being overheard. The use of tape recordings for personal interviews required careful handling to avoid voice recognition; thus tapes were transcribed and stored off-site.

Written data, such as questionnaires and transcripts, were anonymised with codes. However, as the content of coded transcripts could clearly identify some speakers, access to these was tightly restricted. Health services professionals tend to be a rather close community whose membership is highly mobile. Thus it is quite possible for people working in quite different geographical and specialist areas, including the university, to be familiar with some of the study participants. For this reason access to the transcriptions was limited to myself as researcher and my university supervisors; material would only be presented to the 'public' arena in a collated format.

It was agreed that, once the study was completed, anonymised transcripts and questionnaires would be lodged with the university, with limited access. Thus material will be available for verification purposes but not general reading or secondary research, consent for this having not been gained from the study participants.

Publication

In publication, it is possible to err on the side of caution, to the detriment of the study. For example: Lathlean (1996) described how in the writing of her study of ward sisters, adherence to the maintenance of confidentiality resulted in a report that was deemed bland by the study participants, and had lost much of the essence of the situation. In the majority of instances, an individual's identity can be hidden within the presentation of basic socio-demographic data and their responses hidden within collated formats or presented as variations on a theme. The situation becomes more problematic when reporting issues that related to a few specific people, of example the actions or reactions of the Clinical Director or Senior Midwifery Manager - individuals who, although not named, could be immediately recognised by those familiar with the situation. One of the advantages of a longitudinal study proved the movement of individuals within the NHS which helped confuse identities.

Issues of confidentiality were compounded by the high national profile of this service development. Total anonymity could not be assured and indeed was not considered necessary. The desire for anonymity does presuppose compromising or negative reporting; in highly successful developments individuals may welcome the publicity, particularly if they feel they have some control over the presentation. Also, identification of the study site for professional audiences is helpful for those seeking detailed information about such changes. Thus, when presenting at conferences, permission was sought and given to name the study site.

Professional Responsibilities

Ethnographic research within one's own profession carries the potential for a particular ethical problem for the researcher: that of a conflict of responsibilities towards the research community and the professional body. The witnessing of unacceptable clinical practice, and resulting conflict of revelation and betrayal, never arose in this study, although the potential dilemma was recognised.

The 'problem' of feed-back of information into the research site altering the field, was not considered a difficulty; in evaluative studies it could even be considered unethical not to feedback particular concerns as they are identified. As this study involved a change process aimed at improving client care feedback was considered fundamental. This was done on an informal basis as a member of the team overseeing the project implementation and evaluation. For example, by highlighting particular concerns raised by specific groups, clarifying positions when some confusion became apparent, and outlining different perspectives on recognised problem areas. This also proved useful to the work as an understanding of the responses of the managers was developed. Caseload midwives were also involved in conference and seminar presentations, and their responses proved a helpful check on the validity of aspects of the analyses.

Closely involving participants in all stages of the work, by frequent feedback and discussion about issues as they become apparent, helped to avoid unexpected disclosures at the end. This allowed those studied a sense of being active participants rather than passive subjects, that they maintain some sense of control, even ownership of the study. Nevertheless, maintaining the balance of the study between participant involvement and academic rigor was my responsibility.

Data Collection and Analysis

This section focuses on the operationalisation of the ethnography, addressing the decisions made concerning the selection of data, manner in which they were collected and handled, and analysed.

The aims and objectives of the study, as outlined at the beginning of this chapter, were to address the meaning of caseload midwifery for professionals. This broad remit was focused down to the following specific research questions:

- **What were the professional and personal implications of carrying a caseload for these midwives?**
- **How did caseload midwifery practice differ from the conventional midwifery practice in this maternity service?**
- **What were the implications of the introduction of caseload midwifery for the midwives and obstetricians who continued to work in the conventional service?**

Addressing these questions raised a number of further questions and ‘sub-questions’ as the data collection and analysis informed the ethnography and the study became progressively focused and refined. Two areas that were considered of importance related, firstly to the issue of generalisability of the findings and consideration of how far they were related to the particular study situation, and secondly identifying a differentiation between individuals’ concerns and their experiences. These were formulated as:

- **What was unique about this situation and these individuals?**
- **What issues were likely to pertain to the local situation and what to the typology of practice?**
- **What were the common ‘myths’ and what was the ‘reality’ of this situation? i.e. what did individuals fear and what was their actual experience?**

Ethnography is essentially a reflexive and responsive activity in which the process of data collection and analysis is iterative, one informing the other (Turner, 1988) as opposed to a processual collection then subsequent analysis of the data. The research develops and is responsive to the situation although an overall research design guides the direction of the work. In this study the design encompassed the following features.

- 'Sensitisation' to the study site was undertaken by the 'participation' of living and working on-site, Monday to Friday and some weekends, 'being', observing and participating in the social setting that was being studied. This later included undertaking clinical midwifery practice.
- The perspectives of groups identified as pertinent were sought by interviews and survey questionnaires
- Understanding of particular phenomena were sought by participant observation, interviews, survey questionnaires and analysis of relevant documentation as found appropriate.

The study was originally envisaged as lasting three years. However, the real world rather than idealised world of research, acknowledged by Bryman (1988) and Robson (1993), necessitated responding to staff changes and limitations of funding by my assuming other responsibilities with the wider evaluation in addition to the ethnographic research. Although the ethnography was subsequently undertaken on a 'part-time' basis, this proved advantageous in facilitating further acceptance within the study site and, by prolonging the duration of the study, an understanding of the development of the service beyond the implementation phase. As the additional roles involved work within the study site this served to increase an understanding of the situation rather than detract from this.

Whilst participation in the life of the hospital, both as a researcher and clinical midwife facilitated an understanding about the situation and culture of the unit, more focused data were needed to gain an understanding of the implications of caseload midwifery. Participants were identified and invited to participate in the research in the following manner.

Participants

An ethnographic study undertaken in the 'natural setting' of the maternity services offered the potential involvement of very large number of participants. Apart from the problems of obtaining everyone's consent (Homan, 1991), and the generation of a large quantity of data, much of which could be tangential, the limited resources of one researcher needed to be acknowledged. Clearly for practical purposes choices had to be made about who to incorporate and in what manner to be most effective. These are summarised in Table 4.

Midwives

Caseload midwives

As the focus of the study was caseload practice it was considered important to obtain as accurate an understanding of the nature and range of the midwives' experiences as possible, and to gain some understanding of how things developed and changed over time.

All midwives who carried a caseload were invited to participate in a range of data collection methods that commenced May 1994 until the end of August 1997:

- Initial individual interviews, exit interviews on leaving the project (39 interviews).
- Focus group meeting of original midwives and of new midwives at 46 months (8 midwives).
- Baseline survey questionnaire, at 12 months and more detailed questionnaire at 45 months.
- Observation of personal practice (six midwives)
- Participation in and observation of group meetings throughout the study duration.
- Informal contact. This was maintained throughout this period on a day-to-day basis as the midwives used the facilities situated on the project corridor where the research offices were located (administrative office, sitting/meeting room, kitchen, seminar room) and the hospital canteen. Informal meetings, e.g. 'bumping into' individuals when making coffee, helped establish an identity as a 'friendly and

ever-present face', a 'persona' facilitated by almost constant availability (7am-10pm). Such 'informal' contact generated a quantity of important data.

Table 4: data collection - participants and methods

Midwives:		
Caseload midwives	individual interviews (28 participants) 'exit' interviews (11)	
<i>May 1994 - end</i>	focus group interviews, 2. (4 & 4 participants)	
<i>Aug. 1997</i>	observation of practice, 6 midwives (experience with caseload: 46, 46, 34, 26, 20, 2 months) numerous observation of group meetings questionnaires 2 (75% & 86% returned) numerous informal meetings	
Community midwives	focus group interview, 1 (10 participants) Individual interview, 1	
<i>Spring 1995</i>	Observation of working practices, 3 midwives Questionnaire to G grade sisters Numerous informal chats, 1 participant informal chats (notes made), 6 participants	
Hospital midwives	Individual interviews, 9 Focus group meetings, 3	
<i>ANC. June 1995</i>	(participants:duration - 3:120, 2:40, 5:60mins.)	
<i>Ward Jan. 1996</i>	Questionnaire to G grade sisters (minimal response)	
<i>D.U. June 1996</i>	Observation of delivery unit situation, 11 'rounds' Informal chats during personal clinical practice	
Student midwives	individual interviews, 12	
<i>1994; 1996-1997</i>	Focus group meetings, 3	
Medical Staff		
Consultants	individual interviews, 11	<i>Nov. 1994-Jan. 1995</i>
Registrars	individual interviews, 5	<i>June 1995 &</i>
SHOs	individual interviews, 9	<i>Jan. 1996 (3)</i>
Managers		
Action Group	individual interviews, 5 exit interviews, 2 close participation in numerous meetings and daily work	
Midwifery managers	'informal' interviews, 9	
Business Managers	individual interview, 2 exit interview, 1	

Hospital midwives

An understanding of the hospital midwives' perceptions of caseload practice and of how it affected their work was important, particularly in view of the difficulties both mothers and caseload midwives reported concerning care during admission. The views of the midwives working in the larger, maternity hospital were focused on for formal data collection as a greater number of individuals were involved and, in view of the medical-orientation of this service, their work presented a greater contrast to caseload midwifery. Nevertheless, the perspectives of the midwives working in the smaller unit were also gained through working with them on the wards and through interviews with one sister and two E grade midwives (self-selected).

As it was recognised to be impractical and unnecessary to interview all the midwives in the hospital, key actors were identified and invited for personal interview and a sample of midwives sought for focus group interviews. Caseload practice and hospital practice interfaced in three separate areas. Midwives working in these areas were treated as specific groups and targeted separately: antenatal clinic staff, ward staff and delivery unit staff, although it was recognised that staff rotated through all three departments. In view of this rotation, all clinic staff in June 1995, and all staff on one ward in January 1996 were approached; a convenience sample that was considered unlikely to present any particular bias. Individual interviews were held with the relevant sisters (clinic and ward) and focus group interviews held with the midwives shortly afterwards.

Delivery unit presented more difficulty due to the numbers of midwives involved and the constant pressure of work. Individual interviews were held with the senior sisters (June 1996) but it proved difficult to arrange focus group interviews with the midwives. This was then considered unnecessary when the midwives from the other two groups also talked about their experiences on delivery unit and when an understanding of the midwives' position, enhanced by personal experience, was gained from the many midwives who chose to chat freely with me whilst working together. The ethical dilemma this presented is considered elsewhere. All midwives were encouraged to talk 'formally' with me in my researcher capacity, and three did so. Interviews were arranged with them, two together and one alone.

Community midwives

It was considered important to gain an understanding as to why few of the community midwives had applied for caseload practice. Also, although the community midwifery service did not interface directly with caseload practice, some of the community midwives had been 'displaced' by the service development and strong emotions were reported within the group.

The views of all the community midwives were obtained in spring 1995, 17-18 months into the project, in the following way:

- the majority participated in a focus group interview (10 of 14).
- A personal interview was conducted with the one midwife who had been 'completely displaced' by the caseload project.
- three days were spent accompanying three different community midwives, observing the nature of their work, and discussing their views concerning caseload practice. This was a self-selected 'convenience' sample; a request was made and three midwives volunteered. Managers reported these participants as not being particularly 'different' from their colleagues. Co-incidentally, two had not been involved in the focus group meeting and it was considered important to learn their perspectives.
- Numerous informal chats were held with the community office administrator and several of the community midwives in their office; also when meeting with them in the corridor, canteen or on delivery unit. The development of an understanding of the community midwives' position was further refined during frequent conversations with a community midwife who also lived in the nurses' home.

Student Midwives

From March 1994 students were seconded into caseload practice for part of their clinical experience; their involvement in the research was considered to offer important and very different perspectives. Initially, students were invited to individual interviews; however this proved difficult for them and the uptake poor. A more fruitful strategy proved my attending their first introductory meeting into the project and then their end-

of-secondment evaluation meeting. This was immediately followed by a focus group meeting alone with me; three such meetings were held. Informal chats with individual students as we met in the corridor or kitchen were also informative. One student on missing the focus group interview asked to meet with me and an individual interview was held.

Obstetricians

In the highly medically-orientated maternity hospital the co-operation of the obstetricians was seen as crucial for the successful development of caseload practice. As a group, therefore, their views were considered vital and, in view of the hierarchical nature of the unit, sought independently as individual interviews. These were held with all obstetricians, from Senior House Officer to consultant level, to ensure the range of different perspectives were elicited. Senior obstetricians were interviewed 12-14 months into the project, junior obstetricians at 20-21 months.

An analysis of interviews undertaken with the obstetricians from the larger maternity unit formed the basis of the dissertation for an MSc in Social Research Methods, undertaken during the first two years of this ethnography (Stevens, 1995).

An observation study of the doctors' ward round on delivery unit was undertaken in response to the identification of this activity as a major source of tension, identified by both doctors and midwives. Ten such 'rounds', plus one pilot were observed 43 months into the project.

As the smaller unit was less medically 'dominated', the views of the obstetricians were sought by interview from the three House Officers (at 26 months), the senior consultant and consultant who worked on both sites, but not from the two consultants who were rarely involved in 'routine' work. Informal conversations with the two registrars suggested no new perspectives were forthcoming.

Managers

Several different groups of managers were involved in the maternity service and their participation was sought accordingly:

Project managers:

- Formal individual interviews were held with the four members of the Action Group who managed the implementation and continued to oversee the project. A second interview was held with two who left during the study (at 18 and 20 months) and the project manager in January 1997.
- Initial participation in weekly and *ad hoc* meetings as a member of the Action Group and subsequent 'observation' of such meetings
- informal contact was maintained with the majority of Action Group members on a day-to-day basis as, occupying adjacent offices, I was proactively involved in anything they considered helpful to the research.

Other Managers:

In the early days of the project all the midwifery managers were met, the ethnographic research explained and their initial views on the project sought. Although a few notes were made, such meetings were not considered 'formal' ethnographic interviews, the intention being to undertake these once the project had become established. These managers were not involved with the management of the project and it was considered important to obtain their perspectives on any 'clashes' with the hospital service once these had become apparent. With the movement into Trust status, a layer of middle managers was removed 'overnight' and the 'formal' interviews never held.

Individual interviews were held with the business managers for the clinical directorate of obstetrics and gynaecology; other members of this group participated as the senior obstetricians from both hospitals and the head of midwifery as member of the Action Group.

Others

A few individuals were approached, mainly as a response to an appreciated difficulty. The consultant obstetric-physician was interviewed as caseload midwives were caring for high- as well as low-risk pregnancies, whilst the consultant haematologist was approached in response to a specific difficulty which had developed involving their department. Less formal conversations were held with the obstetric physiotherapists and ultrasound scan department when problems developed concerning referral from caseload midwives; such meetings were more in the nature of 'clarification of issues' than ethnographic interviews although where notes were taken consent for their use was obtained.

Groups not approached

The limited resources of one researcher meant that some groups who were or might have been affected by the development of caseload midwifery were not targeted during the research. These included the obstetric anaesthetists, paediatricians, hospital administrative staff such as ward clerks, and General Practitioners. However, the perspectives of those in the hospital were not completely ignored; personal contact during clinical practice generated a degree of awareness, as did the responses reported by the hospital and caseload midwives during interviews. Participant observation of the GP forum meeting, and involvement in another community-based GP meeting provided some, albeit limited, understanding of their position.

Data Collection Methods

Ethnography as ‘participant observation’

The overall pattern of data collection over the 46 month duration of the study is presented as Table 5. Participant observation was considered by Hammersley and Atkinson (1983) as a ‘cognate’ term for ethnography and, as indicated in Table 5, this was the basis of this study from which other forms of data collection were defined as appropriate and undertaken. The issues of access and field roles, which Hammersley and Atkinson (1983) noted may present difficulties particularly in hierarchical organisations like a hospital, were not problematic, as already discussed. I was ‘employed’ to undertake an ethnographic study and a ‘role’ as a researcher was pre-determined.

However, different roles were assumed in the study in response to changing circumstances during the course of the research project. This meant that, although Gold (1958) defined four different types of participant observation, for this study I found myself constantly moving between a continuum of three of them; from participant as observer to observer as participant and back. Gold’s fourth type, covert observation, was never a feature.

During the ‘working’ day, implementation of the project and development of the evaluation generated a number of meetings, both formal and informal. As a member of the evaluation team, involvement in the research activities combined with the ethnography so that participation in these meetings was important. When responsibilities for the evaluation were assumed by a research manager and the ethnography took precedence, a field role as a participating researcher was already so established that continuing attendance at these meetings was accepted as ‘normal’, although acknowledged this was for ‘observation’. The meetings proved one importance source of ‘knowing what was occurring’ in caseload practice which was undertaken mainly in the community. Although the meetings focused mainly on issues and problems, knowledge about what arose and how it was handled provided ‘structural’ features of the project and a frame for the ‘understanding’ that later developed.

Table 5: The pattern of data collection.

[illegible]

Exploring

Defining

Progressive focusing

Less formal participation in the life of the hospital occurred out of 'office hours'. Like other training hospitals, this maternity hospital incorporated a 'nurses' home' and canteen; for a number of employees it was their 'home'. At the time of the study, mainly student midwives, cleaners and visitors stayed in the nurses' home, but also a few midwives, including one of the caseload midwives and a community midwife.

Staying on-site in the home enabled participation in the 'life' of the hospital late at night and early morning. Working in the project offices, situated on the ground floor of the nurses' home near the canteen, I 'lived' in the centre of the non-clinical life of the hospital. This facilitated the establishment of informal relationships, and I became sensitised to what was 'going on', particularly issues which were more personal than the management ones that arose during the day. This held the advantage that when I came to seek midwives' views through interview, I was able to build on established relationships and had an awareness of important issues to be explored in this more defined way.

Data collection and field-notes

Being immersed within the life of the study site proved immensely valuable in gaining an understanding of the culture and sensitisation to certain issues. However, as Hammersley and Atkinson (1983) warned, this was highly subjective data – in what was observed, what was considered significant or important, what my subjective presence generated in terms of people's responses to the research and researcher, and the decisions concerning what to record.

In one sense data 'collection' began on first arrival at the hospital. An 'understanding' of the study site began to develop from the time of first entry, as in 'traditional' ethnography where anthropologists enter and live within a strange society, attempting to make sense of 'what is going on' (Baillie, 1995). However, recording every sight, sound and smell, would have generated vast and unmanageable amounts of data; thus selection, and a degree of analysis commenced in the reflection and decision of what was recorded (Silverman, 1993). Initially this was limited to very general 'first impressions' made as brief notes in a diary to be used as 'reminders' to help counterbalance the danger of 'going native' (Hammersley and Atkinson, 1983) and

avoid forgetting perceptions which might subsequently prove important in informing the analysis.

Subsequent focus for notes was mainly a description of 'events', in particular the 'issues' that arose and peoples reactions to these. Mindful of warnings concerning the danger of recording 'impressions', the concentration was on recording 'facts' and verbatim quotes (Spradley, 1979). The initially generally broad remit of recording anything that 'seemed' useful or 'different' in some way, became increasing purposeful as the focus moved to issues considered relevant in response to the themes developing from the ethnography, see Table 5.

Notes from meetings and daily occurrences were recorded in chronological order, constructing a hand-written 'diary' of events. Other forms of data recorded after the event, e.g. an insightful corridor chat, were noted straight on to computer. A variety of computer text files were used to record and order the data, each record being categorised and cross referenced in files labelled '*chats*' (containing notes and verbatim quotes), '*issues*' (emerging as important), '*thoughts*' (my personal reflective questions and ideas generated by 'being around', not data but areas to think about whilst working), and '*check out*' (issues that arose but, unable to use as data, needed to be followed up). Excel spreadsheets were used to record data collection events, providing a chronological record of the study.

Personal clinical practice

This study sought to understand the implications of caseload practice from a variety of perspectives and it was considered important for this to be perceived as more than rhetoric. As a member of the evaluation team, I was clearly identified with the project and the likelihood of bias in favour of caseload practice being assumed by midwives working elsewhere was high. To counter this perception, joining the midwifery 'bank' for occasional shifts, and subsequently being contracted to work two shifts per week, proved a useful way of gaining an understanding about the culture of the organisation and the position and experiences of the hospital midwives working within it.

This was undertaken as an E grade midwife, working on the smaller site for six months, rotating around the unit, and the larger site for 18 months on the delivery ward where,

given the larger numbers of midwives working per shift, I could merge more readily into the general staffing.

Genuinely wanting to refresh my skills in hospital midwifery, and E grade being a recognised position of learning, enabled a questioning approach to be adopted with minimal threat to anyone concerned. I was on the unit to practice midwifery and to learn how to do it 'their way'. Midwifery staffing at this time was perceived as being reduced and I found myself welcomed as a willing pair of hands on both units.

It was ethically important to avoid any actual or perception of covert observation occurring. This was addressed by wearing a name badge stating 'researcher-practitioner' rather than 'midwife', in this situation an unusual title that invariably generated queries from colleagues and clients. These enabled an open response, and frequently generated a discussion about the study, but also reassurance concerning current focus on clinical work rather than research.

No notes were made whilst working 'on-duty'. However, reflection on personal experiences and practice generated copious notes, made after completion of a shift. These proved important in informing the analysis of the culture of both hospitals and consideration of factors that influenced people's behaviour.

Such experiential understanding of the working of the maternity service was helpful in gaining an understanding the culture of the environment in which caseload practice had been implemented. However, a more targeted approach for data collection was necessary to account of the range and depth of people's reactions to caseload midwifery.

Interviews

Although a broad range of perspectives were gained from being immersed in the study site, talking with people and generally participating in the daily life of the project and hospital, it was important to focus the data collection and to explore the perspectives of the various groups involved with or affected by the project. This was achieved by undertaking individual and focus group interviews.

The aim of the interviews was to develop an understanding about caseload practice from the perspective of particular groups, identifying and exploring the range and depth of issues considered important by each group. To facilitate developing a group specific

perspective, all interviews within each groups were undertaken around the same time. The wider ethnography helped to contextualise this work, providing an understanding of any time-specific bias e.g. particular events that influenced individual's perceptions, that could then be accounted for in the analysis.

Oakley (1993) highlighted that the 'theory' of interviews as a means of data collection holds to a scientific objectivity that bears minimal resemblance to the ethnographic interview. In the ethnographic approach, interviews are social events that are socially situated and, as such, will be influenced by this social nature (Hammersley and Atkinson, 1983). The implications of undertaking such interviews within a highly hierarchical organisation were clearly recognised and care was taken to emphasise a non-hierarchical, social element of the interaction.

Particular attention was placed on the manner of initial contact, provision of information and timing and place of interview. Different strategies were used for different categories of staff, with more formal approaches being adopted for consultants and more personal, informal approaches used with the midwives. Nevertheless, the principles of promoting transparency of intent, and negotiating a timing and venue of the participant's choice, preferably away from their work site, were maintained. Local pubs, restaurants and a health club were popular venues; where participants could not leave their work-site, the nurses' home sitting-room or my office, suitably re-arranged, were used and refreshments provided. The doctors usually elected to use their office or a quiet room where they were working, a situation which moderated the social nature of the interview. Privacy was considered vital and sought in all venues.

The relationship between the interviewer and interviewee is an important element in achieving quality of information (May, 1993); as Oakley highlighted, the "*mythology of hygienic research*" is replaced by a recognition that personal involvement is not a 'dangerous bias' but the condition under which people admit others into their lives (Oakley, 1993:242). This study was politically extremely sensitive. Honesty in response to the probings of the ethnographic interview held the potential for serious repercussion for individuals, particularly doctors whose reputations might later be questioned and the caseload midwives who, for personal or professional reasons, would not want to admit 'failure'. Thus establishing and maintaining the perceived and actual integrity of the research and researcher was paramount. No interview was undertaken

until my 'persona' had become known and I could be related to with honesty and trust (Fontana and Frey, 1994).

Personal interviews are usually classified into three groups – structured, semi-structured and unstructured (May, 1993; Fontana and Frey, 1994). However, another form of classification emerged in this study in which the interview was defined along a continuum of formal to informal. This reflected the social distance between interviewer and interviewee negotiated during the interview, and the engagement of the person of the interviewee as opposed to the role they were projecting.

'Formal' interviews (invariably doctors), tended to follow a longer period of negotiated agreement over the purpose and method of the interview; the participant talked with varying degrees of input by researcher, but there was less empathy or emotion and it was a more intellectual discussion about an issue. In contrast, 'informal' interviews occurred where the 'interview' was part of a more social occasion, such as a meal or drink in the local pub. In these occurrences issues of mutuality, and elements of 'friendship' were apparent, as both interviewee and interviewer became 'engaged' in the issues discussed.

Many of the interviews undertaken tended to move between these two poles, starting more formally and becoming relaxed as the conversation progressed and the interviewee became less guarded in their exemplification of issues raised. However, all interviews were conducted along the same premise: the interviewee determined the nature of the event, whilst as interviewer I remained responsive yet encouraged informality.

Wherever they took place and whatever the degree of formality, all the interviews followed a similar pattern. In seeking to identify and explore individual's perceptions and reactions concerning caseload practice, it was considered inappropriate to either impose a specific structure or facilitate a completely unstructured interview; the former denied an opportunity to identify the unexpected, the latter denied the opportunity of exploring the range and depth of previously identified phenomena. In practice, the interviews were reflexive rather than standardised (Hammersley and Atkinson, 1983) utilising a 'check list' compiled prior to the meeting, as a strategy for ensuring all the desired issues had been addressed. As an *aide memoire* the check list was not an intrusive or directive strategy for controlling the interview, but enabled the interviewer to keep track of issues and not forget something if side-tracked by an unexpected revelation. Later in the research, when particular issues had been identified for further

exploration, a more focused technique was used, whilst still allowing space for the unexpected to emerge.

The initial period of introduction included addressing Spradley's (1979) 'explicit purpose' and 'ethnographic explanations'. Definitions of the purpose of the study were always framed in a 'lessons to be learnt' approach that acknowledged the uniqueness of the implementation and potential value of the work for other units contemplating similar service developments. This approach served to 'de-personalise' the purpose of interview, making it less threatening and of defined value. The proposed method of data collection, recording and handling were outlined and issues concerning confidentiality and anonymity clarified.

With consent, interviews were tape-recorded to avoid the researcher bias inherent in data collected by taking notes. It also ensured accuracy of participant's views, particularly the actual words used and the meaning conveyed in the tone of voice, for example the use of sarcasm. Tape recordings also facilitated an analysis of the impact of the researcher on the discussion, identifying leading questions, domination of discussion etc, which was particularly helpful as learning strategy for a novice interviewer.

Care was taken to minimise any inhibiting effect of the small recorder used, and acknowledging the possibility of technical problems, concurrent notes were made. Tapes were checked after interviews and notes written up immediately if any loss of recording identified. In view of the danger of loss of confidentiality in transcription due to voice recognition, all tapes were kept off site and transcribed elsewhere by a stranger.

Very occasionally participants chose not to have the conversation recorded, (one consultant; 2 caseload midwives' exit interviews which were both held in a restaurant), and occasionally the tape recorder was not functioning. On these occasions, the notes made were written up immediately after the interview whilst the memory of the conversation was clear, and transcripts were offered to be returned to the participant for validation.

Discussions and 'corridor chats'

A number of discussions were held with individuals that did not constitute either formal ethnographic interviews or 'friendly conversations' in the sense described by Spradley (1979). These included the meetings held with managers on my arrival, which were mainly introductory and 'sensitising' in purpose, meetings undertaken with particular individuals (e.g. physiotherapists) in order to clarify specific issues, and discussions with members of the Action Group as they reacted to the daily events involving caseload midwifery. These meetings were not taped recorded but notes were taken of particular issues that appeared significant at the time. Similarly, a useful form of 'sensitisation' proved the informal and serendipitous meetings that formed part of the day-to-day participation in the life of the hospital; the informal 'listening and asking questions' of Hammersley and Atkinson's (1983) fieldwork.

These encounters generated an important form of data, enabling a clarification or refinement of particular issues, or the identification of new ones. Despite the informality, however, care was taken that no records were made without the consent of the individual involved.

Focus group interviews

Focus group interviews were useful where the views of a larger group were sought. Clark *et al* (1996:143) defined focus group work as "*simply a discussion in a small group of people under the guidance of a facilitator. talk about topics selected for investigation*". In this study they proved a valuable technique for discussing more general 'issues' with a number of individuals, rather than exploring the more personal 'meaning' that might lie behind particular phenomenon. By encouraging general participation, particularly the exchange of anecdotes and commenting on each other's experiences and points of view, and by guiding the conversation using open-ended questions, participants were encouraged to explore their experiences, using their own vocabulary, generating their own questions and pursuing their own priorities (Kitzinger 1995) in relation to caseload practice. However, as focus groups involve a 'public' arena, individuals are less likely to express 'deviant' views and the influence of dominant individuals needed controlling; the skills of the interviewer as moderator were paramount (Fontana and Frey, 1994).

As generally advised (eg. Kitzinger 1995) group numbers were usually small (4-6 participants) although occasionally larger when circumstances rather than choice dictated. A number of open-ended questions were identified beforehand, generated from previous interviews or observation. However, once initiated, conversations were easily maintained requiring minimal input apart from the occasional new question, request for clarification, or encouraging the participation of quieter participants.

A tape recorder was considered not sensitive enough to record all participants so notes were taken by the researcher and, when a larger group was held on one occasion, by a research colleague. These notes were returned to participants for validation.

Survey Questionnaires

By imposing a pre-determined frame of reference on the respondents, as a method of data collection questionnaires held only limited value in a study that sought to uncover and explore what was not known about a situation. Nevertheless, their selective use offered the advantage of easily eliciting the views of all members of a particular group with the safety of anonymity, and enabling all views to be considered equally. In this study they were used on two occasions:

- At the end of the first year a simple survey was sent to all caseload midwives and all midwifery sisters working in the hospitals and the community. This was administered in the form of a brief letter explaining the purpose of the communication and requesting they identify five positive and five negative points about the caseload service. The letter was sent via the hospital's internal post system and anonymity was ensured. This survey was undertaken in order to obtain a 'snap-shot' of current views to provide a reference point with which to compare changing views as the service developed.

The response rate from the caseload midwives was 15/20 - 75% but was extremely poor from the midwives working in the conventional service: 12/48 - 25% although representation from the three services involved was indicated.

- At the end of the data collection period of the study all midwives who had worked with a caseload were sent a questionnaire (see appendix 2). A basic format was modified according to whether they were currently employed in caseload practice, on maternity leave, or had left the service. This was administered as a 2 or 3 page

questionnaire accompanied by a covering letter, by post. Although the letters were sent to named individuals, confidentiality was maintained by the questionnaires being coded rather than named. This mechanism enabled reminders to be sent where necessary; two reminders were sent. Freepost envelopes personally addressed for the attention of the named researcher and labelled 'confidential' were included for midwives not currently working in the service.

The aims of the questionnaire were:

- To confirm and complete the socio-demographic data on the midwives
- To obtain as wide a possible view of the service in general, and as it had affected them personally.
- Identify areas of the service that required improvement.
- To identify if, and if so how, they thought the service had helped them develop.
- To identify changes in views that had been obtained previously.

The structure of the questionnaire was informed by the researcher's knowledge of the situation gained through preliminary analysis of the data already collected and so it enabled a testing of the strength of particular issues, for example the perception that working this way had caused the midwives to develop considerably.

The response rate was 19/20 (95%) for current practitioners, one was not returned by an individual who was leaving shortly and had just completed a long 'exit' interview; 3/3 (100%) from those on maternity leave; and 8/12 (67%) from those who had by then left the service. Of the four who had left and did not return their questionnaire, one had stayed six months in the service and one left the Trust just as the questionnaire was sent out and had been interviewed again. Thus potentially important data was lost from only two practitioners who had had more than one year's experience with a caseload.

Focused Participant-observation

Data were also collected through more formal, defined periods of observation that focused on specific activities at three separate points in the study. In the context of the wider participant-observation nature of the study, these episodes of data collection are defined as focused observations.

1) Community midwives

The first 'set' of observations were undertaken accompanying community midwives on their "*visits*". The aim was to gain an understanding of the way they worked, considering the constraints and advantages of this model for midwives (as opposed to mothers). Three sets of observation were undertaken with different midwives, all of whom were 'self-selected', volunteering to take me out; one had an accompanying student midwife. The purpose of the study was explained to each midwife prior to the observation, and they were requested to seek the mothers' informed consent for the presence of a researcher before I was introduced, where possible on the preceding day. The reality that this was achieved on some visits but not others appeared to reflect individual midwife's attitude regarding authority and control; a degree of sensitivity was required to negotiate a form of consent morally acceptable to the researcher when the midwife being observed appeared to consider another midwife had an automatic right of entry to a mother's presence.

The 'observation' periods lasted from three hours to five hours. Discussions about their work that took place in the car were, with the midwives' consent, taped and contemporaneous notes made. With mother's consent, notes were made during the visit, which were further expanded as appropriate once the visit was completed.

These observations also offered the opportunity for a more prolonged chat with individual midwives during the course of their work. Undertaken following the focus group interview with the community midwives, they offered the opportunity for expanding on issues raised and gaining further understanding about the perspectives of the community midwives and nature of the service they offered.

Following each observation episode the notes were checked and clarified and subsequently 'married' with the tape transcription. Only one midwife accepted the request to read through and validate the notes; no comment was made on the returned set.

2) The obstetric ward round on delivery unit

The second 'set' of observations were made towards the end of the study period, focusing on an activity that had been identified in the preliminary analysis as causing concern to both midwives and obstetricians and a site of conflict of interest. Exploration of the issues was sought by undertaking observation of the 'morning round' over 11 weekdays.

Consent was sought and gained from the relevant managers, both obstetric and midwifery, and an information letter with contact details sent to all involved obstetricians and midwives informing them of the proposed study (see appendix 3). Each morning of the observation consent was again sought from every individual involved. Permission to accompany 'the round' into the rooms of the mothers admitted to the unit was sought from each couple by the midwife who had cared for them overnight – this being considered more ethical, a relationship having been formed and a more honest response easier to achieve in these circumstances.

To obtain participants' consent and an understanding of the context in which each 'round' was situated, I arrived on the unit before the change of midwifery shift which occurred with a 'handover' report in the office at 7.30am. Observation of activities that occurred within the office were noted continuously until the obstetric round commence. This usually started around 8.40- 9.00am and lasted 30 minutes to over an hour depending on the workload on the unit. The 'team' was accompanied throughout, except in the few instances where consent from couples had been refused, when I remained outside the door.

On completion of the 'round' both the senior participating obstetrician and the sister-in-charge were asked separately to comment on it, noting any deviations from norm that they were aware of so as to enable valid judgements to be made concerning that observed. At each episode, the notes made were written up immediately afterwards to enable their expansion whilst memory was fresh.

Ten rounds were observed over two weeks following an initial 'pilot'; the findings of an analysis that focused on the nature of the visit was presented to the hospital forum during a study afternoon later in the year.

3) Caseload midwives' practice

The third observation 'set' focused on the nature of the caseload midwives' practice as they experienced it. It was undertaken towards the end of the data collection period to enable the observation of midwives experienced in carrying a caseload as well as newer ones to be made. Six sets were undertaken involving three partnerships as a self-selected convenience sample that was identified by each group where both in the partnership were available, and they expected to be moderately busy rather than quiet.

The observation was undertaken following the same procedure as with the community midwives, although it was noticeable that in general mothers were expecting me, consent having been obtained prior to my visit in most cases where the visit was planned. Notes and tape recordings were taken and the two sets 'married' as described before. Again only one set was returned to the midwife although all were offered; minimal alteration was noted on its return.

Whereas the observations made on community midwifery practice were undertaken with a view to sensitisation rather than addressing preconceived questions, those undertaken on the caseload midwives had a more defined purpose. Preliminary analyses on data already collected informed the compilation of a list of issues to be addressed

However, the compilation of an exact observation schedule was considered inappropriate. The intention was to gain a more substantive understanding of the nature of caseload midwifery practice than that revealed through discussion, remaining open to issues not yet revealed whilst exploring the relevance of issues previously raised. Although appreciating the time lapse between observation sets, this also offered the opportunity to make some tentative comparisons between the nature of caseload practice and the more conventional form of community midwifery. The results of this comparison were considerably stronger than expected, revealing striking differences in both attitude and substance of the care the midwives delivered to their clients. Nevertheless the numbers involved were too small for generalisations to be made based on these observations alone.

Documents

As previously noted, documents were acknowledged as 'constructs' as opposed to 'accurate' accounts of events (Scott, 1990). However, access to the directorate reports relating to caseload practice, to the JMC meeting minutes and delivery statistics was facilitated. These were used as reference and clarification of specific issues as they emerged from other sources of data.

Data handling

Immediately after data had been collected it was checked for comprehension and clarity whilst the memory remained 'fresh' and clarifications could be added if the tape or notes proved unintelligible. When the tape had not been used, notes were written up as quickly as possible, usually immediately afterwards (six hour maximum delay). Notes from focus group meetings and two interviews that were not recorded were returned to respondents for checking with the suggestion of adding further comments or elucidation if desired. One interview respondent declined to check the notes, the majority returned them without comment. A coding system was used to anonymise data and a backup of computer files was maintained and stored off site.

Data Analyses

Data analysis in this ethnography was inductive in approach, aiming to inform and generate theory as opposed to testing it (Blaikie, 1993) and undertaken as a continual process rather than specific activity following data collection. Also, a variety of different techniques for analysis were utilised in an interactive and iterative process as outlined by Huberman and Miles (1994) and Coffey and Atkinson (1996). These will be described below.

As with many ethnographies the potential for generation of an overwhelming amount of data was ever present. Selection was imperative and formed an 'immediate' type of analysis in defining what to record and what to 'ignore'. Nevertheless, the generation of a large amount of data was a particular feature of the interviews, reflecting both the initial inexperience of the researcher, and the desire to establish positive relationships with participants whilst encouraging fruitful reflection. Also, the participants appeared to use the interviews as a relatively 'safe' form of 'sounding board'. As the study progressed the interviews were increasingly focused in response to an awareness of the

situation and the requirement to explore particular issues, although participants were encouraged rather than curtailed in their reflections. This was considered appropriate, both as a form of reciprocity and as a check for missing aspects.

A preliminary form of analysis was undertaken relatively early in the study recognising the iterative process of data collection and analysis in order to develop particular themes whilst being open to changes and new issues. There was also the requirement to address particular aspects for the evaluation report (McCourt and Page, 1996). This raised the potential danger of imposing a personal or etic frame of analyses. To try to avoid this bias and remain open to the views of the participants, the interview transcripts formed the main focus and core of the preliminary analyses.

Analyses of interview transcripts:

With the intention to seek an emic perspective from each separate group involved, data sets obtained from each group were analysed separately and, initially, without reference to other data or analyses.

As they were the central focus of the work, analysis of the original caseload midwives' interviews were undertaken first, during the first half of the study period. All available transcripts were skim read then, in view of the length of some of the interviews, detailed open coding, as defined by Strauss & Corben (1990), was undertaken on a randomly selected half. However, two were specifically selected as also being 'exit' interviews, two of the original midwives resigning after six months. These were coded in an identical manner but also interrogated with a view to identifying reasons for leaving and if there were possible differences between these and the remaining midwives.

The defined list of categories were then collated, grouped together as issues and organised into potential themes. The remaining transcripts were read in detail but coded only when the issues pertained to previously defined categories or where new and obviously important categories were raised.

The 'exit interviews' undertaken when a caseload midwife left the project, were processed in a similar manner, an initial five being coded in detail and subsequent transcripts being analysed for supporting or contrasting data, or identifying new categories. These transcripts supported particularly rich and fruitful analyses, as they had provided the opportunity to explore issues that had become apparent during

fieldwork and the categories and initial themes that had emerged from the preliminary analyses of the interviews.

A similar process of focusing was used when dealing with the interview transcripts from the other participants. Where the amount of data collected from a particular group was relatively small, all transcripts were closely coded (hospital, community and student midwives); where more extensive data had been obtained (the obstetricians) a proportion of the transcripts were coded in detail (generally half) and the remainder coded in less detail, in order to develop identified themes but remain open to consideration of new areas.

In two areas, a development of the analyses involved a sub-group analysis undertaken to identify any changes or differences between particular members of the group: a comparison between the perspectives and experiences of the original and the subsequent members of the caseload practitioners, and between different levels of obstetricians.

Comparison between the three different levels of obstetrician involved (consultant, registrar and house officer) was undertaken using a matrix (Strauss and Corbin, 1990), formulated from the themes identified from the coding. This enabled comparison of the issues raised by different members of the group, clearly identifying common features within and between the sub-groups. This work formed the basis of a MSc dissertation (Stevens, 1995) so is only summarised in this thesis.

The initial coding sought to identify the issues that, being raised by them, were probably of particular relevance to the group being analysed. However, as Hammersley and Atkinson (1983) noted, other issues were 'observer-identified'. In recognition that some issues may not have emerged as being particularly significant during the interview yet were of potential importance, the data were then interrogated addressing a series of questions identified through a process of personal 'mind-mapping' which drew from knowledge of the study situation and the professional background. The intention was to build as clear and comprehensive an understanding of particular perspectives as possible.

When the perspectives of the individual group had been studied and specific themes identified, these were then developed by reference to alternative data sources, enabling the issues raised to be viewed from alternative perspectives. This involved a gradual

process of withdrawal from the individual (group) perspective to achieve a more overall, etic perspective.

An example of this was ‘problems within caseload partnerships’ which was a clearly defined category emerging from the initial coding of the transcripts. This category was further informed from an awareness of tensions gained when being around the caseload midwives who were experiencing such problems. The wider category of ‘colleague relationships’ was developed, expanded and refined as data collection continued. What was initially a major hiccup in the project became viewed as an important feature which needed to be addressed for successful work. This incorporated the ‘developing maturity’ of the midwives to deal with personal conflicts, recognising it to be a group rather than individual problem. Such skills were recognised to be not so readily developed within the conventional service. Thus this category formed part of the main theme of support and also the nature of caseload practice versus the conventional service; the initial coding of ‘friction’, became included in the final themes of ‘support’, ‘development’ and ‘differences’.

Key issues that had been identified as important from the analysis of the caseload midwives’ transcripts were included in a questionnaire that was sent to all the midwives who had been associated with the project at the end of the data collection period. As well as ensuring a comprehensive data set of descriptive statistics, this formed a valuable test of the transcript analyses, confirming the significance of issues identified and indicating the range and strength of the issue involved.

Questionnaires

Analysis of the two sets of questionnaires administered were both undertaken as simple content analysis as the numbers were relatively small. This involved a process of collations of each response and categorisation within each question. The emergent themes were found to compare closely with those from the interview analysis; thus this analysis served to both validate and summarise these themes.

Participant Observation

The data obtained from the different sets of formal participant observation were necessarily analysed in different ways.

Eleven sets of data were obtained from the study undertaken on delivery unit. Once the notes were written up, they were divided into particular events: pre round issues, individual episodes, post round issues. Each individual episode was defined on colour specified cards according to room category (admission bay, delivery rooms, recovery), and marked (hole punch) according to category of midwifery staff involved (caseload, hospital or community) to facilitate comparison between each episode. Analysis was undertaken focusing on specific, predetermined issues that had been defined following analyses of interview data.

The pre-round notes were analysed using a similar process as that used for the interview transcripts. The objective of the study had been to explore the nature of the obstetric round, which had been defined as a 'social visit' by obstetricians and 'interventionist' by the caseload midwives. However, the analyses of the pre-round congregation of staff, use of the 'office' space, and staff interactions also proved illuminating, offering new perspectives on themes which had already been identified and broadening an understanding of particular issues.

Analysis of the observations of midwives' visits was undertaken in a similar way to the interview transcripts as much of the data was in the form of extended conversations. However, analysis of the observation of the content of the midwife-mother interaction, as opposed to language used, was helpful in determining the nature of midwife-mother relationships which had been identified in the analysis of the interviews.

Notes made during meetings attended were not analysed individually but were clarified, categorised according to type (caseload group, management, GP forum) and then used as reference to support, confirm, and clarify issues raised within the wider analyses e.g. to clarify the timing of issues, or the ways in which matters were discussed. Rather than generate new lines of inquiry, these data were used as important sources of reference, as were reports and minutes of specific meetings accessed in response to particular questions raised by the wider analyses.

'Field notes' and reflective notes made following personal clinical duties were not analysed in depth but clarified and stored for reference. As the study progressed the iterative process of the analyses enabled an immediate awareness of issues that were likely to be of significance. Once identified these were recorded in detail after gaining permission for their use, and noted in the appropriate analyses files for inclusion in the detailed analysis.

At a number of stages during the course of the study, specific analyses were required to meet the needs of the directorate and for conference presentations. As the caseload midwives were frequently involved in such presentations they formed a useful mechanism for validation of these analyses.

The final level of analysis for this thesis was undertaken once data collection had been completed. The main themes that had been identified were then developed with reference to the published literature, further data re-interrogation and reading being undertaken in an iterative process.

It was clear from this work that the data was particularly rich and would support development and analyses of various aspects. Choices had to be made as to the focus of this thesis. The themes selected were those that emerged as being fundamental to caseload midwifery practice *per se*.

This study was not undertaken as an 'isolated' exercise of academic interest but as a response to the operationalisation of changes in the philosophical conceptions surrounding childbirth in England. The nature of the model of midwifery implemented and the maternity service in which it was situated had both developed in response to particular circumstances. As an understanding of neither can be achieved without knowledge of these background influences, these are explored in the following chapter.

Chapter 3

THE BACKGROUND

*“The midwifery services do not exist in a vacuum...
(they are) just one element of a changing kaleidoscope”
(Green et al,1998:1)*

Childbirth, a physiological process and culturally shaped social act (Kitzinger, 1989), cannot be considered outside the particular sociological context in which it occurs as changes within that society will affect the experience and meaning of childbirth for those involved. Some changes require consideration in order to appreciate the significance of caseload midwifery and its meaning in terms of organisation of care and implications for midwives.

Giddens (1990) drew attention to globalisation as the major change of the late 20th century resulting, in the main, from the technological revolution. Few societies remain untouched by the web of communication and interdependency. Social relations were once restricted by time and space to form dense ‘embedded’ features of a society. Now they have been ‘lifted out’ from local contexts and become restructured across infinite spans of time and space, forming the “*disembedded*” features of Giddens’ “*runaway world*” (1990, 1999). Inevitably, such major change has impacted on childbirth. Once both symbol and structure of family life and domesticity, childbirth is now a process that forms the specialisation of specific institutions and target for the advertising forces of giant multinational companies.

The last century has brought two fundamental changes to childbirth in England. Firstly, a strong movement from private to public involvement has affected the domain of childbirth itself, and the regulation and employment of childbirth attendants. Secondly, technological advances have developed the fields of fertility, conception and childbirth, causing the moral and ethical norms held by society to be questioned. Both have had important effects on the experiences of childbearing women and their attendants.

From private to public domain

The movement from family control to state responsibility

Traditionally, childbirth has been considered the domain of the family, and to a lesser extent the local community (Loudon, 1992). In England it is only since the turn of the last century that childbirth and those who care for childbearing women have become the concern, and within the control, of the nation state.

The importance placed on the procreation of children has been central to controls exercised over women's fertility and the care with which marriage arrangements were conducted. Negotiations over political liaisons, economic considerations about inheritance or family income, and even spiritual aspects involving the continuation of ancestral lines have been major considerations for generations, in addition to a general liking of and desire to have children (Levi-Strauss, 1960). Successful childbirth elevated a woman's status, increasing her power within the domestic, if not public, arena.

Such an important activity was held within the control of the family and close community. Childbirth took place within the home, and women supported women through the birth process, drawing on a variety of mechanisms believed to be both preventative and curative to help ensure a safe outcome of what was recognised as a hazardous process (Butler, 1981; Donnison, 1977).

However, many of the functions of the family began to be assumed by the rise of the nation state. In particular, care was provided for the needy through the developing welfare state. This occurred during a time when there were major positive changes in health status due to developments in technology, sanitation, education, diagnosis and treatment of communicable disease and the beneficial impact from changes in housing and the environment (McKeown, 1989).

As the state became more powerful the nature of the family was changing, becoming smaller and more isolated. The demographic transition, more effective modes of fertility control, increasing divorce rates, positive changes in the legal status of women such as emancipation and legal rights pertaining to ownership of property, and attitudes

towards female employment challenged traditional notions of the family and family life (McKeown, 1976; Halsey, 1986; Symonds and Hunt, 1996). An increasing mobility of the work force encouraged the development of the nuclear family and promoted the separation of childbearing women from the close community they grew up in. The control element of the family institution was diminishing, but so was its supportive function.

Giddens (1999) suggested that, by the end of the 20th century, marriage and the family had become “*shell institutions*”; a familiar name but inside their basic character has changed. The couple, married or unmarried, now form the core of a family which is no longer based on an economic role but on emotional communication or intimacy (Giddens, 1999). Attitudes towards children have also changed; prized because of their rarity, their potential for economic benefit is replaced by a large financial burden. A study cited by Morley (1986:42) indicated by the age of 15 a child in Java has, by his labour, repaid his parents their economic investment whereas children in Britain will have cost their parent \$100,000 by the age of 16.

Having a child in England is now a specific decision, guided by psychological and emotional needs, and understood against the background of higher expectations about how children should be cared for and protected (Halsey, 1986; Giddens, 1999).

State involvement in childbirth – policy and the consumer

Direct state involvement in childbirth has been a phenomenon of the 20th century. State concerns over maternal and child health were raised following the recognition of the poor size and condition of recruits for the Boer war, and the continuing requirement to provide ‘soldiers for the Empire’ (Lewis 1980; Oakley, 1984; Hannam, 1997). Pressure from the Women’s Co-operative Guild and others, and concerns about a falling birth rate yet high infant and maternal mortality figures, prompted an increase in a publicly funded provision of maternity care and legislation relating to birth attendants and birth notification (HoC, 1992). The 1907 Notification of Births Act and 1915 Extension Act gave the Local Government Board powers to provide grants to local authority and voluntary bodies to support these schemes, made notification of birth compulsory, and extended the role of health visitors (HoC, 1992). This effectively gave the state a mechanism to monitor births and facilitated an increasing level of control over birth

attendants. Childbirth no longer remained a private matter but was of public significance.

Access to health care was improved by the 1911 National Insurance Act which involved weekly compulsory payment by workers entitling them to sickness and maternity benefits and services of a 'panel doctor'. The importance and provision of antenatal care developed throughout the 1910-1920s, particularly highlighted by Dr. Janet Campbell who, although focusing on midwifery training, stressed the importance of antenatal supervision, preferably by a medical practitioner (Campbell, 1923,1924).

The feminist view that mothers were coerced into the hospitalisation of childbirth as passive actors or pawns under the domination of the powerful professions (Donnison, 1977; Oakley, 1984) has been questioned. Given the poor housing conditions, low nutritional levels and generally poor health of many women, the recognised health problems related to childbirth and the desire for assistance, pain relief, and time to rest and recover, led many to seek hospitalisation, and those unable to afford it to complain (Beinart, 1990; Lewis, 1990; Hunt and Symonds, 1995). It is difficult to estimate how far changing attitudes towards childbirth influenced the situation, but notions of 'modernity' and the 'process of civilisation', as opposed to the 'savage' nature and pain of 'primitive' unassisted childbirth, were gaining momentum (Loudon, 1992) and undoubtedly influenced the move towards hospital birth.

Private lying-in hospitals had existed in England since 1739 (Lewis, 1989). However, state involvement was not forthcoming until the 1918 Maternity and Child Welfare Act, which enabled Local Authorities to provide clinics, home visiting and maternity beds in nursing homes or existing institutions. Further access was achieved by the 1929 Local Government Act, which encouraged the movement of the Poor Law hospitals into municipal control, so reducing their stigmatised image (Hunt & Symonds, 1995). Not everyone eagerly availed themselves of the perceived benefits. As Leap and Hunter (1993) noted, poor working class mothers were reluctant due to lack of 'appropriate' night clothes or fear of leaving their husbands alone, whilst the wealthier who could not afford private nursing home fees were reluctant to mix with those in the public hospitals.

An alternative, more natural approach to childbirth, and in particular pain relief, gained some popularity during the 1940s-50s with Grantley Dick-Read's psychological approach to relaxation (Kitzinger, 1990). Nevertheless, increasing reliance on the advantages of technology was apparent and an awareness of the development of spinal anaesthesia in America enabling painless childbirth at this time was noted by Hunt and Symonds (1995). It is clear that a strong impetus towards hospital care during childbirth, which was increasing during this time (Table 6), came as much from women themselves, seeking pain relief and or rest from domestic work, as from the strategies of obstetricians (Arney, 1982).

Table 6: movement to increasing institutionalisation of birth

1927	15% births in hospital
1933	24% births in hospital
1937	25% births in hospital
1946	54% births in hospital

Source: Lewis, 1990

Increasing mortality figures after 1931 prompted a government investigation (DoH, 1937) which highlighted the clinical causes of death and also an inverse relationship with maternal economic circumstances, a phenomenon Loudon termed the 'reverse social class connection' (Loudon, 1997): the higher mortality rates were found amongst the wealthier, who were more likely to use the hospitals and medical services (Loudon, 1992, 1997). However, movements to improve women's position at home through the use of home helps or even the acknowledgement of women's poor health being linked to poverty were firmly rejected by the government (Lewis, 1990). Hospitalization of childbirth was considered the only way to avoid maternal deaths, although statistics indicated otherwise (Loudon, 1992; Tew, 1990).

The most fundamental change in the provision of maternity services came with the 1946 National Health Act and subsequent implementation of the National Health Service (NHS) in 1948, when women became entitled to free medical and midwifery care and hospital treatment if required (Loudon, 1992). As Hunt and Symonds (1995) highlighted, this reflected a period of social reform and nationalisation of all public utilities, with hospital births reflecting the egalitarian and modernising ethos of that time. Post-war daily life became more open and public, and state involvement in

private life increased. Popular images of hospitals and the glamorous portrayal of doctors and nurses on radio and television programmes promoted an attitude of deference to the medical profession; doctors became "*trustworthy miracle workers in white coats*" (Hunt & Symonds, 1995:15). Hunt and Symonds (1995) also suggested that a 'normalisation' of hospital was achieved by a movement of hospital values into the home; preparation for delivery involved adopting hospital techniques of hygiene, and acknowledging professional expertise and elements of control in the domestic arena. This movement was also reflected in the increasing popularity of books concerning childcare written by 'experts'. What was once considered intuitive knowledge was becoming 'professionalised' and, not only was 'private' becoming public, but 'public' was encroaching into the private.

Maternity care at this time was becoming safer with a reduction in maternal mortality rate resulting partly from pharmacological and clinical developments (Loudon 1992) and improvements in standards of living (McKeown, 1976). However, care provision was divided. Under the NHS, antenatal care could be provided at a General Practitioner's (GPs) surgery, by the Local Authority midwife or by a hospital doctor and midwife. As hospital and community midwifery services were separated, continuity of midwifery care was only achieved for home deliveries. GP involvement in maternity care increased with a specified fee being provided if they were registered on the obstetric list. Access to care regardless of economic circumstances had been achieved, but that care was fragmented and further involvement of the medical profession, the GP, encouraged.

This provision of maternity care by three separate professions within the NHS, and the problems it generated, formed the main focus of subsequent government concern. The declared MoH policy for 50% hospital confinement had been exceeded by 1952 at 64%. However, whilst promoting further hospital facilities, the Guillebaud Committee's (1956) review of 'the obstetric service under the NHS' recommended an investigation into the confused state of the maternity service. The Cranbrook Committee (1959) merely confirmed the tripartite system, suggesting that division of responsibility would require reorganisation of the NHS. Nevertheless, they also recommended sufficient beds to accommodate 70% of all confinements in hospital, and recommended the initiation of local Maternity Services Liaison Committees to encourage good communication between all parties involved (Green *et al*, 1998; HoC, 1992).

During the 1960s maternity services were delivered against a background of a falling birth rate, increasing hospital births, 'shared care' with GP and midwife, and under utilisation of the community midwife's skills. The situation was reviewed in 1967 by the MoH Midwifery Advisory Committee – chaired by the obstetrician Sir John Peel. Their recommendations (DHSS 1970) included facilities for 100% hospital births on the grounds that it afforded greater safety for mother and baby, a recommendation since challenged (Tew, 1985, 1990; Campbell & Macfarlane, 1996). The tripartite division of care was again noted and the need for greater team-work stressed (Green *et al*, 1998; HoC, 1992).

Nevertheless, as Kitzinger highlighted (1990) childbirth itself remained a somewhat taboo subject for many, shrouded in ignorance and secrecy. A delivery screened on television in 1957, and a photograph printed in the Sun in 1965 both prompted public outrage. Childbirth was seen as primitive, animalistic (*Sunday Pictorial* 11 Nov.1956) and, by association with natural functions such as defecation and sex, degrading; for some, 'sanitization' was sought from hospitalisation (Kitzinger, 1990).

As the move towards hospital birth increased, the 1973 Reorganisation of NHS Act, changed the management structure of the organisation with the development of Regional and Area Health Authorities (RHAs & AHAs). RHAs assumed statutory responsibility for midwifery but delegated this to the AHAs or districts where it was placed with the Head of Midwifery Services. The valuable links the community midwives had between Social Services and the Local Authority were broken (McCourt, 1998). Community and hospital midwives now had the same employer and manager but the service provision remained fragmented; antenatal, parentcraft and late postnatal care was provided by community midwives, whilst delivery and early postnatal care by hospital midwives. General Practitioners remained independent, separate from this management system yet sharing responsibility for care provision (HoC, 1992, Green *et al*, 1998). In attempting to streamline the system, this change had effectively introduced a 'Fordist' factory mode of production to the service delivery which became perfected during the 1980s.

By the late 1970s attention again focused on the maternity services, concern being expressed about high perinatal mortality rates and a proposed decrease in maternity services funding in view of the falling birth rates (HoC, 1992). In responding, the Social Services Committee report (1980) outlined 152 recommendations which

supported further hospitalisation of childbirth: hospital deliveries were supported over home for reasons of safety of mothers and babies; the delivery unit was to be considered and staffed as an intensive care area; and all women should see a consultant obstetrician twice during their pregnancy.

Their proposals led to the setting up of the Maternity Services Advisory Committee and subsequent reports *Maternity Care in Action* (1982, 1984, 1985) which provided the template of maternity care for the next decade. These endorsed the integration of community and midwifery care but trapped midwives into functional areas providing fragmented components of care to women (RCM, 1993:paper 4).

By this time childbirth was predominantly an institutional process managed by highly trained specialists (Table 7).

Table 7: The decline of home births

1960	33.2% home,
1970	13.0% home
1980	1.20% home

Source: Macfarlane & Mugford (1984)

What had once been an individual and private affair had become a more public phenomenon, taken over by professional ‘public servants’. The degree of authority which they commanded can be appreciated in recognising that the 1960-1970s was a period when an anti-establishment attitude developed in many areas of British life. The adversarial culture of students, intellectuals, journalists and the media, plus the expansion of universities and rise in females receiving higher education (Halsey, 1986) might have acted as a strong counter balance. Indeed this period saw the development of a number of consumer activist groups working in the field of maternity care (Durward and Evans, 1990).

The National Childbirth Trust (NCT), originally set up in 1956 as the Natural Childbirth Association promoting the philosophy of Dick-Read (1959) and then Lamaze’s theories as an alternative, more natural method of childbirth, gained immense popularity during this period (Kitzinger, 1990). A second consumer organisation, the Association for Improvement in Maternity Services (AIMS), was established in 1960 as a direct

response to the founder's bad experience of antenatal care. As a campaigning pressure group, AIMS also provided support and information concerning legal rights and clearly digested research findings, easily accessible for consumers of the maternity services (AIMS, 1992). The Maternity Alliance, established in 1980, took a broader remit that included maternity benefits and rights as well as health care, thus mirroring its predecessor, The Women's Co-operative Guild, in focusing on poverty and the dependence on and needs of working mothers (Durward and Evans, 1990).

As the movement towards a centralised, hospital system of maternity care grew stronger, such groups campaigned in particular against the closure of small local maternity units and supported women who had to 'fight' to obtain 'permission' for a home birth, as many GPs removed such clients from their panels.

Partly as a result of the action of such groups, an increased consumer involvement in the service delivery began to be developed during the 1970s and 1980s. Both women and midwives raised concerns about increased number of inductions of labour, and the dominance of a medical approach to childbirth (Schwarz, 1990). The views of consumers were acknowledged and the Maternity Services Liaison Committees (MSLC, mid 1980s) and Community Health Councils (CHCs) established as routes through which women could voice their opinions on maternity services. Nevertheless, Garcia & Garforth (1991) suggested any effective input of the MSLC, although variable, was severely restricted by a variety of factors and likely to have been minimal.

A concurrent development within the health service was the ideology of the market economy and an increasing ethos of consumerism in service development and provision. In a client-centred service, it was considered purchasers would be unwilling to buy a service that women did not want and was perceived as uneconomic. Thus policy documents focused on quality of care and the need to avoid duplication of responsibilities. The Cumberlege report on community nursing (DHSS, 1986) included community midwives in advocating practitioners be allowed to utilise skills and knowledge to offer comprehensive care and choice to patients. The need to improve communication between professionals, and clarification of roles and responsibilities was also noted (Green *et al*, 1998).

Subsequent documents from the Department of Health, *Working for Patients* (1989), *Caring for People* (1990) and *The Patients' Charter* (1991) promoted these perspectives with the 1990 National Health Service and Community Care Act emphasising consumer choice, quality of service and audit. Nevertheless, in the 1990 Act the Health Authorities were appointed as the *de facto* consumer, buying services on behalf of the local population; likewise with fund-holding GPs. With no really effective transfer of power to consumers this formed a quasi-market economy system with a highly managerial focus (McCourt, 1998). Moreover, as the three MSAC Reports remained the basis on which contracts were set, the ethos of a compartmentalised service was maintained.

In 1991 an all party House of Commons Select Committee, chaired by Nicholas Winterton, was directed to review the maternity services, it having been 10 years since the last inquiry and there was growing recognition of:

*“many voices saying that all is not well with the maternity services
and that women have needs which are not being met.”*

(HoC, 1992: v)

The prospect of a major change in the delivery of maternity care, moving away from the predominantly medical model of childbirth, was recognised (Ball *et al*, 1991). Women might warmly welcome such change but it would hold important implications for those who attended them in childbirth. Not only had the domain of childbirth radically changed during the preceding 100 years but also the occupational status of those who cared for mothers at this time.

Attendants at birth: from private to public servant

Author: *"Houwa, you tell me these things are important for a pregnant mother to know but that you, her TBA, cannot tell her about them; Why is that?"*
Houwa: *"If she asks me, then I can tell. I cannot tell her without her asking or her family will think I am trying to get power over her".*
(personal conversation with a Traditional Birth Attendant, Maldives, 1985)

The movement of the site and locus of control over childbirth in England, from private to public, has been reflected in the status of those attending childbearing women. The 20th century proved a period of enormous change for birth attendants, as their occupation underwent what has been referred to as a process of professionalisation (Sandall, 1996), a topic developed further in chapter nine. However, not all the changes necessarily benefited either themselves or the childbearing women they cared for.

Traditionally, women provided support to families and friends during childbirth, and currently Traditional Birth Attendants (TBAs) continue to provide such care in the majority of the world (WHO, 1999). Occasionally their work is limited to family members, as is the custom in Pakistan; more commonly TBAs form an occupational group which is frequently familial. Knowledge required is passed between generations and skills learnt during apprenticeship training (Jordon, 1989). TBAs are acknowledged to have special attributes and skills recognised by the community who use them. An ambiguity of the occupation lies in dealing with dirt and ritual pollution (Douglas, 1966) yet working in the liminality between life and death. Although frequently of low status in society, the TBA is recognised to hold the potential for great power as she supports mothers during this dangerous period. Nevertheless a variety of mechanisms may be used to control her powers (Jordan, 1993; Vincent Priya, 1992; Lefèber, 1994; Laderman, 1983). In Houwa's situation, quoted above, control involved taboos surrounding the giving of knowledge which, if 'inappropriately' provided was considered to constitute witchcraft.

Such characteristics of TBAs, found in many resource-poor countries today are likely to have applied to birth attendants working in England prior to the late 19th century. As experienced by Houwa, illustrated above, control was frequently exercised through the mechanism of witchcraft accusations (Butler, 1981; Donnison, 1977) and church regulations concerned with social and religious aspects of midwifery (deVries, 1989). The birth attendant was called, and remunerated as appropriate or able, by the family.

The relationship was direct and defined; a failure on either part to meet expectations could result in not being used or refusal to attend. The midwife was an independent practitioner.

Changes in what was originally a supremely female occupation can be paralleled with a development of technology. The development of writing and, in particular, printing, facilitated the transmission of knowledge; however, restraints on female education limited women's access to this so that ideas and developments in the field of childbirth were limited to interested men (Radcliffe, 1967). Experience remained the teacher of most midwives (Arney, 1982). The 13th century establishment of barber-surgeons guilds made it an offence for women to use surgical instruments; this necessitated men being called to assist with problem situations. The gender divide, between female 'passive' supporting and male active intervention, was enhanced by the rise of the 'male' techno-rational scientific methodology. It was also encouraged by a consumer-led demand for pain relief and assistance with difficult deliveries, both resources being successfully controlled by men (Loudon, 1992; Beinart, 1990; Donnison, 1977). Nevertheless, Loudon (1992) argued that an increasing involvement of 'male-midwives' from the 18th century was also a result of women's choice, rather than 'need'. This might have been a response to the growth in obstetric knowledge and practice offering a sense of reassurance for women who appreciated the dangers inherent in childbirth. It also reflected a society that increasingly prized technological developments. However, such services required payment and so remained the privilege of the wealthy.

What may be considered as the most destructive force to *supportive care during parturition* (my emphasis) were the late 19th century female social reformers who successfully hijacked the role of birth attendant in their attempt to 'professionalise' midwifery. An alternative view suggests that this movement 'saved' midwifery from the increasing power of 'obstetricians' strategising to 'take over' and medicalise childbirth, as occurred in America (Arney, 1982). In a highly patriarchal society, nursing and midwifery were seen to provide a gendered identity for middle class women that enabled them to create and sustain a valued position and status within society, rather than be subsumed by enforced domesticity (D'Antonio, 1998; Donnison, 1977; de Vries, 1989; Heagerty, 1997; Hannam, 1997).

The demands for suffrage were supported by the view that it was a woman's duty to contribute to social progress through promoting moral regeneration and reform (Hannam, 1997). Such overt political manoeuvrings were disguised as attempting to control the negative aspects of caregivers, as epitomised in Dicken's 1843 portrayal of the lay-midwife, Sairey Gamps, in *Martin Chuzzlewit*. The aim was to replace the image of an illiterate, ignorant, dirty and frequently drunk birth attendant with an educated and 'willing handmaiden of Science' promoting the values of bourgeois society to working-class women. However, Heagerty (1997) pointed out that Louisa Hubbard's Midwives' Institute comprised a group of well-placed trained nurses and hospital matrons, yet few ever practised as midwives, preferring to work as supervisors of obstetric wards, matrons of maternity institutions, and managers of philanthropic organisations. Such movement for change was very much a 'top down' affair.

Although they succeeded in instigating a 'professionalisation' process in midwifery, the consequences were the development of a hierarchy of authority in which birth attendants became controlled and controlling, and a change in their status that caused a separation from mothers. The 'mid wif' was becoming a 'midwife'.

Mid wif to midwife

In seeking legal status the leaders of the Midwives Institute formed an uneasy alliance with the medical fraternity, a tension described in detail by Donnison (1977). A degree of friction was generated by some doctors concerned registered midwives would compete for maternity cases and deprive them of an income. Others supported the registration and training of midwives under their *guidance*, as a means of ensuring the poor had qualified care in childbirth and they had an element of control over the midwives. (Donnison, 1977; Robinson, 1990; Loudon, 1992, 1997). The ninth bill introduced to Parliament was finally passed, with a Central Midwives Board (CMB) directly responsible to the Privy Council rather than the General Medical Council as initially proposed. However, the CMB board of nine comprised of five doctors and no practising midwives (CMB, 1983); the input of practitioners into the formation and control of their occupational authority has remained problematic ever since (Donnison, 1977; see also Ryan and Rogers, 2000; Rogers and Ryan, 2001).

Although the bill related to issues of regulation, supervision and training of midwives, its stated intention was to protect the public against unqualified carers rather than protect legitimate practitioners against competition, unlike legislation relating to other professions (Robinson, 1990). As this development did not include occupational 'closure', i.e. control over entry and practice of their occupation, as reflected in the composition of the Central Midwives Board, this situation gave rise to the debate concerning the classification of midwifery as an occupation or a profession. This contrasted with the obstetricians gaining full professional status, with the development of their College in 1929 and receiving its charter in 1938.

Nevertheless, it gave registered midwives authority over the care of *normal* childbirth and they were expected to refer to medical practitioners whenever deviance was suspected; a situation which later gave rise to questions concerning the definition and scope of 'normal'

The 1902 bill, and the way it was operationalised by the CMB, established a hierarchy of authority exercising control over practitioners that extended into their private lives and morals as well as practice (Donnison, 1977; Robinson, 1990; Leap and Hunter, 1993; Heagerty, 1997). The absorption of the 'bona fide' practitioners and more educated 'handywomen' into regulated midwifery was enforced by the Act which made it illegal for anyone but a registered midwife or doctor to attend childbirth after 1910. Local Supervisory Authorities (LSAs) were set up to supervise and monitor midwives at the local level, reporting to the CMB as required and investigating malpractice where suspected. In developing an extremely detailed 'Rules of Practice' which covered a midwife's personal life as well as practice, and an effective network of control through supervision, the Board sought to ensure that practitioners lost their independence. Also, their loyalty was now expected to be to their profession rather than their client. However, it was clear that many families continued to use the 'unqualified' handywoman as she was cheaper and would help with domestic work, and a variety of strategies were devised to circumnavigate the controls (Robinson, 1990; Heagerty, 1997)

Tensions within the profession, highlighted by Heagerty (1997) and Hannam (1996), and the descriptions offered by Leap and Hunter (1993), indicate a clear divide between the hierarchy of the Midwives Institute, CMB, and Local Authority Supervisors of Midwives and the rank and file of practitioners. A theory-practice gap was already

forming with the expectation midwives would inculcate the social reform agenda of sobriety, cleanliness and sound moral virtues enforced through strict supervision and discipline. Midwives were to be used as means to effect control over the population so that *“independence is maintained and pauperism discouraged”* (Heagerty, 1997:81). The reality of working women’s lives, both practitioners and those they cared for, was very different. In rural areas in particular midwives and handywomen were able to continue to provide care, remaining immersed within, paid by, and part of, the communities in which they worked.

However, Heagerty (1997) suggested that the reformers retained power and by the 1936 Midwives Act undertook a ‘wholesale clearance’ of the older practitioner, to be replaced by the ‘new’, preferably young, single midwife, trained as a nurse and salaried by the Local Supervising Authority (LSA). Mothers were to pay the LSA for midwifery services rather than ‘employ’ the midwife herself. The introduction of a third party into the midwife-mother relationship was to have important consequences. Midwives were assured of an income and guaranteed off-duty and annual leave. However, they were expected to collect the required fee from their mothers, irrespective of ability to pay, a situation found difficult by many (Leap and Hunter, 1993). A commoditised service had been introduced. This denied the flexibility and good-will generated by the reciprocal relationships formed within the preceding arrangement of independent practice. The status of both mother and midwife, and the relationship between them, had been fundamentally altered.

In assuring a salaried occupation, the Act also required tighter educational controls over midwives. Teaching was enhanced through the development of a CMB Teacher’s Diploma, and a residential refresher course for qualified midwives required every five years. Also, the Supervisor of Midwives’ qualifications were defined. By 1938, midwifery training had been divided into two parts, one year for nurses, two years for non-nurses.

An irony of training traditional birth attendants in resource-poor countries is that, once governments seek to regulate and control their work, the number of practising TBAs diminish. A similar situation developed in England during the 1930-40s, reflected in the 1941 Rushcliffe Committee consideration of salaries and conditions of service for midwives, the Ministry of Labour and National Service’s 1943 publicity campaign to attract midwives, and in 1946 the instigation of midwifery training for State Enrolled

Nurses, the shortage of midwives proving critical with the post-war baby boom (Leap and Hunter, 1993). The diffusion of nursing, with a different ethos and outlook, into midwifery was becoming stronger.

Although tightly controlled, and of a higher education and status than many of their clients, most midwives at this time remained based within the community, some offering private care whilst others were salaried by the LSA; a few worked in maternity homes. The majority continued to provide care throughout the childbearing period and were well known by the communities in which they worked. Yet this remained essentially a servant-client relationship, instigated at the choice of, and in the control of the family (Leap and Hunter, 1993; Cronk, 2000).

A major change to midwives' occupational status occurred with the implementation of the NHS, when all women were able to receive free maternity care and the drive for hospital deliveries started in earnest. Although the establishment of the College of Obstetricians had reinforced the trend towards hospitalisation (Lewis 1990), most midwives practising in the community did work with doctors unless an emergency arose. Provision under the NHS enabled General Practitioners to become more involved in maternity care. However, they were under the authority of the Executive Councils rather than the Local Health Authorities who controlled domiciliary midwifery, or the Regional Hospital Boards who oversaw hospital maternity care. As a clear division of responsibilities had not been defined, this resulted in considerable overlap of service provision. This situation increased during the 1960-70s resulting in a fragmentation of care delivery and under-utilisation of the community midwives skills (RCM, 1993). Apart from responsibility for a decreasing number of home-deliveries, community midwives provided some antenatal care, frequently 'servicing' GP antenatal clinics rather than assuming total responsibility for care, and occasionally offered 'late' postnatal care for mothers who had delivered and recuperated in hospital. Both responsibility and scope of practice had diminished considerably for community-based midwives (Barnett, 1979, Brain, 1979, DHSS, 1984).

Although the 1974 implementation of the Re-organisation of the NHS Act 1973 integrated community services with the hospital, the effect on practitioners' work was negligible, apart from closer supervision from a hierarchical hospital management. However, it re-enforced a subconscious movement of the site of midwifery from

community to hospital: midwives now moved from a hospital-base into the community rather than vice versa.

The subsequent movement of maternity services into large, obstetric-consultant-led units, with the closure of the smaller, local GP-midwife-led units proved almost terminal for the provision of a relatively autonomous community midwifery service offering all care to childbearing women. Although a number of schemes were devised whereby the community midwife might accompany a mother into hospital, the reality of midwives assisting a mother she knew to deliver, rapidly diminished over the decade.

Midwife to ‘obstetric nurse’

The rise in the number of deliveries taking place in hospital held important consequences for ‘society’s’ views about childbirth and midwives’ work. By their *raison d’être*, hospitals were related to illness not healthy physiological processes. However, maternity units were usually attached to general hospitals where support facilities were available for medical or serious obstetric emergencies. Childbearing women became ‘patients’, ‘admitted’ to the ‘hospital’, terminology that clearly portrayed the underlying power arrangements (Shirley and Mander, 1996). Practitioners, once guests in women’s homes, became hosts within an impersonal institution, and women became the passive recipients of care.

Staffing such units for a 24hour service was undertaken in the manner devised for nursing; as the majority of midwives were also trained as nurses such arrangements were accepted as normal. Midwives had minimal control over their work; where and when they worked was determined by others, and their practice was overseen on a daily basis by medical staff and managers. To staff the different departments that serviced the needs of childbearing women, midwives experienced increasing fragmentation and specialisation of their practice. This effectively alienated midwives from the ethos of their work, that of supporting women bearing children. Continuity of caring was lost, so that neither midwives nor mothers were able to establish in-depth relationships with each other, and midwives were encouraged to become focused on the task rather than the client they did not know and may not meet again. Loyalty to the institution that paid their salary, and their profession, was expected, rather than to their clients who were now transient passers-by in an increasingly technologically orientated environment.

Even more fundamental, midwives became de-skilled in the work they were trained for. Although rotation through the variety of departments enabled a degree of proficiency to be maintained in most areas, the increasing medicalisation of childbirth resulted in doctors assuming responsibility for what had once been midwifery practice. For example, antenatal examinations undertaken by a midwife were then repeated by a doctor (Robinson *et al*, 1983). A comparison of the studies of care in labour and delivery undertaken by Robinson *et al* (1983) in 1979 and five years later by Garcia *et al* (1985) indicated increasing limitations placed on the midwives' decision making responsibilities, both in terms of the imposition of restrictive policies and medical supervision. When responsibility is withdrawn, skills in decision-making become unnecessary and are less likely to be developed well (Robinson, 1989).

It can be argued that the movement of midwives into hospitals, with an ensuing loss of autonomy and responsibility as they became supervised by doctors, generated a new form of occupation, that of obstetric nurse (Mason, 2001). Most midwives were qualified nurses and, following the Briggs Report 1972 and subsequent amalgamation of the statutory bodies for nurses, midwives and health visitors into one Council, with the 1983 abolition of the CMB, the midwifery professional body was subsumed by the larger nursing one. In both professional practice and control over their occupation midwives had lost authority; the distinction between nursing and midwifery was fast becoming lost in the minds of public and the government (Hunt and Symonds, 1995), although midwives themselves fiercely defended their 'independent' status.

Midwives dissatisfaction with this situation is well documented, particularly by Robinson *et al*. (1983, 1989, 1990), Garcia *et al* (1985), Curran (1986), and Morrin (1982). Both Green *et al* (1986) and Kirkham (1989) highlighted strategies midwives adopted to appear to conform to expected behaviour whilst subverting the system. Some tried to effect change. Sandall (1996) noted how midwives' critique of these changes was informed by the impact of feminism on midwifery and the formation of an alliance between dissatisfied practitioners and mothers. Originating as a support and study group for student midwives, in 1976 more activist practitioners formed the Association of Radical Midwives (ARM). Established with the expressed aim of restoring the role of the midwife for the benefit of the childbearing woman and her baby, they produced a vision for change in the maternity services (ARM 1986).

However, by the late 1980s Durward and Evans (1990) noted the membership only covered 4% of practising midwives; ARM remains a relatively small buck to the overwhelming tide of medicalised midwifery. Weitz's (1987) survey of British midwives suggested that complacency, or perhaps apathy, rather than revolt was the norm.

During the 1980s, alternative ways of practising were developed with the express intention of utilising midwifery skills more fully and improving continuity of care for mothers and midwives. Various forms of team midwifery practice were introduced in many units, for example the Kidlington Midwifery Scheme (Watson, 1990) and Know-your-Midwife scheme (Flint and Poulengeris, 1987; Flint, 1991). Although popular with mothers, such schemes proved difficult to maintain and concern was expressed about the demands placed on midwives, particularly those working part time or with family commitments (Wraight *et al*, 1993; Stock and Wraight, 1993). A small number of independent midwifery practices were established in the 1980s where, freed from the hierarchy of NHS structures, midwives were able to regain the forms of practice enjoyed in the past; but only to a relatively wealthy clientele. The majority of midwives rejected what they classed as the elitist nature of independent practice and remained practising within the NHS maternity service.

It can be appreciated that the birth attendant practising in 1990 was very different from the one practising 100 years previously. The advantages of education, specialist training, assured salary and employment rights and expectations had replaced insecurity of livelihood and poorly resourced working conditions. However, the cost of achieving these advantages had been high.

The occupation of supporting childbirth is now dominated by two competing paradigms: midwifery, which is essentially concerned with supporting the natural physiology of birth, and obstetrics, focused on preventing and treating the potential problems inherent in the process (Downe, 1996, Downe *et al*, 2001). In forming an uneasy alliance and division of labour, the ideology of midwives as practitioners in their own right, although supported in law, has been suppressed by the reality of working, like nurses, as the higher-educated handmaidens of medical specialists (Davies, 1995).

The irony remains that, in the development of a professional midwifery occupation, status has been achieved at the cost of occupational autonomy and independence. More fundamentally, the movement from private birth attendant to public servant, which in itself implies a loss of status, undermined the *raison d'être* of midwifery, that of being with women.

The influence of new technology

If the movements from private to public formed the first major influence on childbirth during the 20th century, the second has been the technological revolution. An understanding of the implications of this revolution is important as midwifery needs to be considered in the context of current challenges to the way society considers procreation. The development of caseload practice may be viewed as a response to some of the problems that a wide-scale adoption of new technology in childbirth has engendered.

Although Gidden's (1990) highlighted how developments in technology have affected every aspect of 'modern' life, in the arena of reproduction 'experts' have developed particular abilities to control and dominate the forces of nature. The use of reproductive technologies and gene therapy may be required by only a few, but such developments have created substantial changes in the way society views the nature of reproduction in general and the status of the foetus in particular.

There is now a clear divide between the biological and social constituents of parenting. Previously only acknowledge in adoption, such divide now facilitates the creation of families that, unassisted, were biologically impossible. The implications for society of a widespread adoption of technologies that alter conventional kinship relationships, such as the use of surrogacy, same-sex parenting, and post-menopausal reproduction, have yet to emerge (Strathern, 1993). However, the specialised and sensitive care required by these individuals during childbirth has been acknowledged (Allen, 1994) , although the attainment of such within over-stretched maternity units is questionable.

Nevertheless, new technologies have also impacted on physiological reproduction to the degree that, at the end of the 20th century in England each pregnancy is carefully ‘watched’ through repeated monitoring and screening tests. Almost no labour remains untouched by some element of technology: epidural analgesia is commonplace and 21% of women ‘required’ major operative assistance to deliver their babies (Thoman and Paranjothy, 2001). Even ‘normal’ birth was associated with some form of intervention (Downe *et al*, 2001), such that the concept of ‘normal’ childbirth became debated (Downe, 1996; RCM, 1997; Lee, 1999;). The physiological process of parturition had become something of an anomaly.

Technological developments clearly contributed towards minimising some of the dangers inherent in childbirth. Improvements in Public Health had a positive effect on maternal health (McKeown, 1976), whilst the development of more efficient transport and communication systems facilitated access to care. The discovery of safe and effective analgesia, anaesthesia, blood banks, and antibiotics had a major positive impact on both the experience and safety of delivery (Loudon, 1992).

However, the value of some forms of intervention were less clear (Chalmers *et al*; 1989). Although developed for positive effect, the actual consequences of some new technologies could be iatrogenic, inadvertently causing harm (Illich, 1975, 1976). Potentially less serious in outcome, but of concern, is the iterative process whereby one intervention leads to another being required to compensate of the problem created by the first; resulting in a ‘cascade’ of interventions. This process Davis-Floyd (1999) called the “One-two punch of technology”, exemplified by the (previously) widespread labour ward policy of reduction in oral intake during labour in case a mother required an anaesthetic; this usually necessitated the use of intravenous fluids. Such issues raise the question why have technological interventions become widely adopted for routine use in what is, essentially, a physiological process, rather than as a response to specific needs or problems.

The use of technology is not recent. Once considered (later disproved) a defining feature of *homo sapiens*, from the development of flint blades, humans have used technology in order to control and manipulate the natural world. World-wide, many different forms of ‘low’ or ‘primitive’ technology are used in childbirth, particularly in relation to the umbilical cord. However, the consequences of their usage tend to be

limited, whereas the ramifications of the use of the 'new' technologies appear widespread, and as if the technology itself acts as a self-determining entity.

A gendered explanation of this phenomenon focuses on issues of domination by an objective, rational, masculine-orientated ethos within society, which emerged from the Enlightenment era (Oakley, 1980; Davies, 1995). The use of technology is viewed as a mechanism for increasing control over both women and nature by a paternalistic, authoritarian medical fraternity. However, this argument ignores the ways women may interact with and use technology to their advantage (Lock and Kaufert, 1998). It also imposes hegemony on doctors that may be false, and belies the unease Price (1993) discovered in the "*shadow dialogue*" behind their discourse. Technology may be 'male' orientated in the type of knowledge within which it is cited, but it remains the content of social relations, not the director, and these relations are not necessarily gender dominated.

The development of new technologies and related knowledge is an iterative process, one building on the other. In this sense technology does gain a type of momentum and, in relation to childbirth, this has been male dominated. The involvement of men in childbirth has been clearly linked to the control and use of technology that enabled the objective transmission of appropriate knowledge (Radcliffe, 1967) and aided delivery (Donnison, 1977). Specialisation, from 13th century surgeon-barbers, to a formalised college of obstetricians (1929) was slow; however the subsequent sub-specialisation within the field of childbirth, obstetric-anaesthetics, neonatology, foetal medicine developed comparatively rapidly and as a response to technological developments.

Had childbirth remained within the home it is unlikely that this expansion of medical specialisation would have occurred, certainly not as rapidly. Hospitals facilitated the development and use of technology that would have been impractical in the home. A concentration of pregnant women in one area facilitated access to the large numbers required for testing and application, and offered economically viable facilities for staffing and training (Declercq *et al*, 2001). This held clear advantages for hospital management and obstetric research. Successful research and developments attract funding, and the ability to offer the latest techniques, such as mobile epidurals, enhances the hospital's reputation, thus attracting both trainees and clients. The process is, again, iterative.

Such use of technology to enhance status is not limited to a local level; with globalisation, new techniques spread rapidly and their adoption holds significance beyond an immediate effect. For example, despite a dictate placed on the importance of small families, the Chinese Communist Party's emphasis on technological innovation in science and medicine as a key symbol of modernity in the 1990s caused their first test-tube baby to be greeted with much acclaim (Handwerker, 1998). Technology enables, but it is the way it is used that generates the power - for the benefit of the state, the hospital or the individual.

Nevertheless, a perception of omnipotence about technology appears to have evolved. As Giddens (1999) noted, the creation of a family is now individualistic, aiming to fulfil the hopes and desires of the parents. Although family size has reduced, expectations of perfection have raised. The emotional and economic investment parents make into childbirth is high but so is the expectance that the 'process' will result in a live healthy child, almost as their 'human right'. There is a faith that technology can achieve the demanded perfection. Anything to the contrary is seen as human failure - to be compensated for through the law courts. However, it is the human element, in the way the technology was correctly used or not, rather than the value of the technology itself that informs the legal debate. Davis-Floyd (1999) suggested that, rather than reassess and modify its use, this situation encouraged increased usage of the intervention; electronic foetal monitoring is the classic example of this (MIDIRS, 1995; Page, 1998; Walsh, 1998).

Lack of personal knowledge engenders a particular reliance on technology. With smaller families and the institutionalisation of the processes of childbirth, few individuals have witnessed a birth, although technology enables childbirth to be portrayed in the home quite frequently. Nevertheless, the images depicted on television are rarely an accurate reflection of labour and delivery (Clement, 1997). As Clement's, (1997) noted, the drama of events, powerful, speedy labours and glamour of doctors replace the 'banality' of typical birth; although she suggested the influence of this distorted picture remains uncertain.

Thus individuals rely on theoretical rather than experiential knowledge; a reliance that often extends to any understanding about their own body. Such lack of self-awareness may undermine confidence in personal abilities regarding parturition and, in Giddens' (1990) terms, increase reliance on technology. Trevathan (1997), in offering an

evolutionary perspective, noted how emotions can influence parturition. This phenomenon was also acknowledged by Wendy Savage (1990) who, when highlighting the importance of a sense of safety in which to give birth, suggested that 'hi-tech' situations may now fulfil that requirement.

However, although offering reassurance, the use of technology may have generated such reliance by undermining other forms of more intuitive knowledge. For example, Whelton (1993) found some mothers relied on confirmation of pregnancy through ultrasonic scan rather than believe their experience of foetal movements. The manner in which American birth attendants used interventions to 'manage' labour and assess progress, denying any ability on the mother's part, has been detailed by Davis-Floyd (1992). Trained in a paradigm that relied on technology, American birth attendants were seen to have minimal knowledge of, and no trust in, the power of physiological labour. This epistemology was then transferred to mothers, encouraging a sense of inadequacy and inferiority (Davis-Floyd, 1992). Although the American experience of developments in childbirth is viewed as the extreme end of a continuum ranging from low to high technological involvement (deVries *et al*, 2001), the potential for technology to promote a separation between a woman and her body, and mother and her foetus has been demonstrated elsewhere (Oakley, 1987).

This potential was highlighted by Pasveer and Akrich (2001) who, in considering childbirth in the Netherlands, noted how both mothers and midwives failed to trust the working of an unassisted body during labour. Women and midwives were seen to experience pregnancy through the markers of technology – ultrasound, triple test, and amniocentesis. Such tests informed about the growth and well-being of the foetus but set up "*obstetrical trajectories*", as mothers became educated in markers that were external to their body. Pasveer and Akrich (2001) concluded the use of technology tended to separate mothers from the experience of their pregnancy, setting up a reliance on technology rather than the ability of an individual to give birth physiologically.

Developments in foetal medicine, although beneficial to many, have also encouraged a separation of the mother from the foetus developing within her. Once a subjectively experienced being, her baby has become visualised, objectified, and an entity considered apart from her. The development of techniques for prenatal screening have enabled active prenatal management in the diagnosis and treatment, including intrauterine management, of foetal conditions (Whelton, 1993). This has given rise to

major ethical considerations and psychological complications for parents as they are faced with bewildering choice and the potential for difficult decisions regarding termination of pregnancy for abnormalities. Whelton (1993) indicated the stress this could generate and the need for very sensitive care and counselling.

The requirement for individualised and sensitive care can be seen as a consequence of a predominant use of technology, and yet is precisely the relationship that is denied by it. Childbirth now takes place within a society characterised by 'disembedded' institutions, where trust has to be placed in expert systems, not people; and the concept of risk replaces that of 'fortuna' or fate (Giddens, 1990). A "technocratic" model of childbirth as defined by Davis-Floyd (1992; 1999) has become the hegemony of modern parturition, see Table 8.

Although commenting on a predominantly American view of childbirth, Davis-Floyd's analysis held strong resonance with the situation that developed in England (Williams, 1997). In offering alternatives, Davis-Floyd (1999) equated the 'humanistic model', which involved a biological-psychological-social equation, with the essence of midwifery. However, the reality remains that the majority of UK midwives have trained and become encultured within the technocratic model.

To change, when the alternative has not been experienced or valued, is difficult, particularly within a highly masculine-gendered organisation (Davies, 1995; Stapleton *et al*, 1998) where the female-gendered skills of support, caring and being with women tend to be invisible. Even the language needed to describe them appropriately has not been developed so that official documents or student curricula fail to acknowledge such skills (Kirkham, 1989; Stapleton *et al*, 1998). Technology is male-orientated knowledge which has become the "authoritative knowledge" (Jordon, 1993, 1997) of childbirth; the knowledge that counts and on the basis of which decisions are made. The paradox for women in this century is that where they have gained increasingly effective control over their fertility they have increasingly lost control over the actual process of childbirth. An irony lies in the manner in which the use of 'modern' technology has caused the mother to be considered as merely the container for the developing foetus, a view held by many traditional societies (Lefèber and Voorhoeve, 1998; Vincent-Priya, 1992). According to the maternal and perinatal mortality rates birth in England has never been 'safer', yet an increasing percentage of women are

scarred by the process, either physically (Paranjothy & Thomas, 2001a,b; Thomas & Paranjothy, 2001; Page, 2001) or mentally (Laing, 2001; Robinson, 2001).

Table 8: The features of a technocratic model of childbirth, (Davis-Floyd, 1999)

- The separation of mind and body: a Cartesian separation most clearly illustrated in the use of epidural anaesthesia.
- The body is considered as a machine: under the influence of Taylor-Fordist industrialisation, childbirth is a manufacturing process where the mother is machine, labour the process, and baby as the product, all supervised by the expert management of obstetricians and midwives.
- The objectification of the patient: the mother is treated as an object, a 'case', the machine, rather than her individuality being acknowledged.
- This results in an alienation of the patient from the practitioner.
- Diagnosis and treatment is from outside in; the aim is to cure, to 'repair' the dysfunction. Childbirth is considered abnormal until proven normal in retrospect.
- Such care is delivered within hierarchical organisations and is standardised.
- Authority and responsibility are inherent in the practitioner, not the patient who remains a passive recipient of care.
- Super valuation is placed on science and technology; alternative forms of knowing are ignored or despised.
- Aggressive intervention is undertaken with an emphasis on short-term results. Potential long-term consequences are ignored.
- Death is considered as a defeat, a failure.
- Care is undertaken within a profit driven system; an attribute more relevant within the current market economy culture of the NHS than the welfare culture of its inception.
- There is complete intolerance of other modalities.
- A gendered ethos develops which involves a devaluation of the feminine and alignment with the masculine.

Childbirth is a rite of passage into motherhood, yet the liminal phase is controlled by an 'authoritative knowledge' based on the reliance of technology and denial of an individual's intuitive knowledge (Jordan, 1993, Donnison, 1977). Women thus dis-empowered rather than empowered by the experience of birthing maybe less confident than ever before to undertake the responsibilities of parenting (Schott, 1994; Page, 1995). Moreover, it is a responsibility that parents frequently assume without the traditional support of family or community to help them (Halsey, 1986; Giddens, 1990; Symonds and Hunt, 1996).

At the end of the 20th century there is the suggestion of a 'post-modern' revolt against 'expert' system (deVries, 1989; Giddens, 1990). The influence of technology has challenged many of the values and norms of society; the potentials of cloning and the use of gene therapy raise spectres that concern many. Childbirth is about humanity, about creating and recreating social relationships. Technology, although a product of social relationships, if used inappropriately appears to deny, even destroy those relationships. It may be used to support and enhance the process of childbirth; its dominance over it is now being questioned (Stanworth, 1987). One of the mechanisms for enabling a change to be wrought involves the practice of caseload midwifery.

A new approach

“What happens in pregnancy, birth and the early weeks of life is of the utmost importance to all of us.”

(HoC 1992)

As discussed, by 1990 dissatisfaction with the delivery of maternity services in England was high. Consistent messages were being highlighted by consumer groups that women were unhappy with the impersonal and fragmented care they received. Long waiting times, being treated like a number and lack of involvement in decisions concerning their care, was detailed (AIMS, 1992). Women wanted to be treated with respect and dignity, have their views acknowledged, their questions answered, and conflicting advice avoided (AIMS, 1992; Reid, 1994; Oakley, 1980).

Care providers were equally unhappy. Many midwives were dissatisfied with the development of their role (Curran, 1986; Robinson *et al*, 1983, 1989, 1990). The proposed reduction in junior doctors' hours and a decreasing numbers of doctors pursuing obstetrics as a career caused concern over staffing the hospital service (McKee *et al*, 1992). The policy of 100% hospital delivery on the grounds of safety had been questioned (Tew, 1986, 1990; Campbell and Macfarlane, 1987) and escalating costs and increasing medical intervention with questionable results (WHO, 1986; Chalmers *et al*, 1989) was causing concern.

In 1991 an all party House of Commons Select Committee, chaired by Nicholas Winterton, was asked to review the current maternity service in relation to the normalisation of pregnancy. Considering evidence taken from both consumer groups and professionals, the committee made 90 recommendations for change. The main emphasis of their report (HoC, 1992) was that pregnancy and childbirth were normal processes that should not be treated as an illness; a change in philosophy from 'no birth is normal except in retrospect' was recommended.

The committee placed considerable importance on the issues of continuity of care, choices in care and place of birth, and the involvement of women in decisions concerning care. It recognised the previous assumptions concerning safety and hospital birth, acknowledged the rivalry that existed between the different professional groups, and considered what women wanted. Care of normal pregnancy by a midwife was

recommended and the committee concluded that 100% hospital confinement could not be justified on the grounds of safety (HoC, 1992).

The government's response to the Winterton report (DoH, 1992) was equivocal. Many of the issues were acknowledged but then ignored, particularly those relating to recognition of the influence of poverty on health (Black *et al*, 1988) that were likely to have a direct influence on maternal and child health (Mason, 1995). However, an Expert Maternity Group (EGM) was established, with the aim of reviewing policy on NHS maternity care, particularly during childbirth, and to make recommendations. This group comprised of both consumers and health care professionals, chaired by Baroness Cumberlege.

Although focused entirely on care provision, as opposed to the wider considerations of Winterton, their report *Changing Childbirth* (DoH, 1993:1) offered a radical reorientation of the maternity service. The principles underlying the recommendations made included centering services on the individual needs of women and their families and enabling them to make choices about who, where and how that care be provided. The centrality of women to the maternity service extended to consumer involvement in planning, operating and evaluating the maternity services (Page, 1995).

Three key principles were identified as underlying effective woman-centred maternity care: choice, continuity and change. In their recommendations the EMG suggested ten indicators of success that should be achieved within five years, see Table 9.

After a three-month period of consultation all the recommendations were accepted and *Changing Childbirth* became government policy for the maternity services. In an executive letter of 24th January 1994, NHS Authorities were advised to review maternity services in the light of the report's recommendations and develop a strategy for implementing these within the resources available (NHS.ME EL(94)9, 1994).

Responses to the suggested changes in policy were, by and large, positive particularly from consumers although both midwives and obstetricians were somewhat guarded (Dunlop, 1993). *Changing Childbirth* was reported to have been hailed by some as a new manifesto for midwives, but correspondence in the midwifery press suggested many were concerned about the implications for midwives (Browne, 1994; Stewart,

1995). There was even the suggestion that this was a major cost cutting exercise on the part of the government at midwives' expense (Bradley, 1993).

Table 9: Indicators of Success suggested by the EMG (DoH, 1993)

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 the 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 a 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.

Midwives' abilities or willingness to work this way was questioned (RCM and CCIT, 1995). Sandall (1996) noted how Weitz's 1987 survey of British midwives suggested there was a substantial number who were not concerned about a need to change their mode of practice, whilst Henderson (1995) reported midwives being apathetic, even hostile to proposed changes. Also, where change had already been effected, Stock and Wraight's (1993) study of team midwifery indicated the problems experienced by midwives with the implementation of various forms of continuity of carer schemes. Clearly the new policy for the maternity services held implications for midwives that had yet to be determined.

This study focuses on a group of midwives who sought to practice the style of midwifery proposed by *Changing Childbirth*. In following through their experiences and focusing on the nature of their work and the difficulties encountered, the implications of attempting to work in a more traditional manner within a highly structure post-industrial society are explored.

Chapter 4

INDIVIDUAL CASELOAD MIDWIFEY PRACTICE

The Wider Context

An understanding of the midwives' experiences of working with a caseload, and the implications this held for both individuals and service development, can only be appreciated in relation to the context in which this took place. The way the model of care was organised, implemented and operationalised, the structure and culture of the environment in which it was situated, and the responses of colleagues with whom the practitioners came into contact all influenced, to a greater or lesser extent, the nature of their experiences.

It is from an understanding of the particular, in this instance the context, that issues of wider significance may be determined and the value of this study assessed. The following two chapters address the 'what?', 'where?' and 'how?' issues by providing a "*thick description*" (Geertz, 1973) of the 'context' in which this model of caseload midwifery was situated.

The following description of the 'environment' in which the development took place addresses both the features of the organisation and offers an understanding of what it was like to work there, perspectives that draw heavily from reflective participant-observation as an 'outsider' living on-site and conducting personal clinical practice as an integral part of participant observation.

The way in which a project is planned and implemented has a significant effect on the way it is received and accepted (Peters, 1987; Moss Kanter, 1994; Belasco, 1990; Broome, 1990). As these stages of the project were undertaken prior to the study, an understanding of this phase is gained from individuals reflecting on the process, and reference to relevant service documentation. Thus it offers a description of how individuals retrospectively perceived what had happened and what features they considered were of importance.

The reactions of the other midwives and obstetricians working alongside the project to the development and the caseload midwives are described in chapter 5. Their

perspectives are understood from observation and experience of working alongside them, as well as interviews conducted with key participants. Although the reactions of colleagues were not the main focus of the study, as they influenced the experiences of the caseload midwives, an overview of their responses is given.

The Organisational Context

The following section presents a description of the structure and culture of the organisation in which the caseload midwifery project was implemented. This understanding was generated from reflective personal midwifery practice undertaken in both units, formal observation of delivery unit practice and interviews with midwives who worked in the hospitals, as well as nearly four years living and working on site so generally 'being around', watching and participating in a variety of ways. This enabled a rich ethnographic description of the units to be generated from which an understanding of the features that both supported and hindered the caseload practice may be developed.

The use of the term 'culture' in this context refers to "*the informal 'concepts, attitudes and values' of the workforce*" (Wright, 1994) as elicited by the study rather than any predetermined, formal management 'culture' imposed on the units. However, this limited definition is used whilst acknowledging the theoretical discussion within anthropology concerning the way 'culture' has been used in the analysis of organisations (Wright, 1998). Also, whilst recognising that cultures are neither static nor homogenous, the dominant features considered relevant to the experiences of the caseload midwives have been particularly highlighted. This will enable the reader to draw conclusions as to how far issues discussed later were related to the local situation or were features of an innovation that might apply elsewhere.

Caseload midwifery was introduced within an inner city maternity service that was delivered from two sites: one undertook approximately 4,000 deliveries per year and formed a stand-alone hospital; the other was part of a large, general teaching-hospital complex, and undertook approximately 1,000 deliveries per year. In this thesis, these units will be referred to as 'the maternity hospital' and 'the maternity unit'. They were very different and their unique situations and cultures are outlined and discussed below. Nevertheless, they were linked by a common management structure and personnel.

Management

In 1984, the stand-alone maternity hospital had, on a management level, formally amalgamated with the larger general teaching-hospital so that, although on separate sites, the two maternity services were then managed as one Clinical Directorate of Obstetrics and Gynaecology (O&G). At the time the project was planned and implemented, the hospital was managed as a Special Health Authority (SHA); this converted to NHS Trust status in 1994.

The majority of the SHA/Trust's administrative offices were maintained within the general hospital complex; however the O&G Directorate offices and a small personnel office were sited at the maternity hospital. The Clinical Director, who was also the academic professor, was based at the general hospital with the smaller maternity unit, whilst the Deputy Director was a consultant obstetrician at the maternity hospital. Initially both sites had their own midwifery managers and a common Head of Midwifery Services was based at the maternity hospital; however, in 1995 the midwifery managers were reduced in number and expected to cover both sites.

The Royal Post-graduate Medical School (RPMS) was attached to the general hospital, and RPMS facilities were located in the grounds of the maternity hospital. Four O&G professors were attached to the School and held honorary contracts with the SHA/Trust, working as consultant obstetricians for the service. With this link, the maternity service offered a medical training facility centre that had achieved a national and international reputation for research and teaching. Both sites were recognised centres for excellence in obstetrics and foetal medicine; the maternity unit attached to the general hospital had become an important referral centre for pregnancies with medical problems; the maternity hospital formed a stand alone specialist unit - which attracted highly motivated career-obstetricians.

Although the two units came under the same management, there was almost no movement of clinical staff between them and negative comments indicated an underlying sense of rivalry. Apart from the managers, the major link between the units was the RPMS and associated research. Obstetric and midwifery positions were site specific, although movement for midwives was negotiated on request. Consultants were

responsible to one or other unit; the majority also worked in other NHS and private hospitals within the city.

There was no public transport system between the two sites. A hospital minibus shuttle was used by staff and for the transportation of laboratory specimens, equipment and post; the journey lasted approximately 20 minutes, depending on traffic conditions.

The Two Sites

The Maternity Hospital

Originating as one of the early maternity hospital in Great Britain, the larger of the two units enjoyed a long-established and world-renowned reputation as a centre of excellence for childbirth (Lewis, 1989). Situated in a fashionable part of the city, the hospital served a relatively wealthy clientele and, with a high-profile reputation, it attracted a considerable number of private patients and celebrities from outside its' catchment area. Well served by public transport the hospital was relatively easy to access, an advantage for attracting staff, particularly shift workers.

The unit comprised a stand-alone hospital for women, providing gynaecological services as well as care in childbirth. A large Special Care Baby Unit and Foetal Medicine Unit focused on the needs of babies, whilst a specialist consultant obstetric physician and three consultant obstetric anaesthetists complemented the team of eight consultant obstetricians. However, with no intensive care (ICU) facility for adults, women requiring this degree of medical support had to be transferred to the general hospital. This undermined the hospital's viability as a tertiary referral point, and the centre of excellence it aspired to be. Also, the buildings were old and requiring extensive refurbishment. The possibility of the hospital closing had been talked of for many years. The prospect of it being re-located on the site of the general hospital, amalgamating with the smaller unit, was under serious consideration at the time of the research.

For security reasons, the grounds of the hospital were clearly defined by railings and high walls; access was through one main entrance and a small side gate, kept locked at night. This physical arrangement of 'containment' had important resonance for the hospital, helping define it and contributing toward a sense of unity amongst those who

worked there. Although its' reputation was belied by a run-down physical appearance, there was a sense of cohesion that employees were a part of a highly respected and famous unit. A large number of staff were employed on site so individuals did not necessarily 'know' one another; however, people recognised and generally acknowledged each other. A sense of unity was also engendered by the familiarity of regular domestic, portering, maintenance and catering staff, - something which was lost in the relatively anonymous world of the vast general hospital. This was particularly noticeable in the canteen.

Providing a reasonable standard of food at subsidised prices in a friendly atmosphere, the hospital canteen served staff and visitors alike and appeared another key factor in reinforcing a sense of cohesion within the hospital. However, in what was otherwise a highly hierarchical organisation, it also provided a liminal space in which the boundaries between professional and individual, clinical and social were broken.

The 'canteen culture' was relatively egalitarian, formally stratified seating arrangements having long ceased; all grades of staff sat and ate together. Different categories of staff tended to stay apart, although such arrangements appeared as much factors of personal ease and courtesy as a particular code of conduct.

As the canteen was commonly used by most of the hospital staff it was an important site for informal communication within the organisation. The discussion of issues during shared meal-breaks avoided the threat inherent in formal appointments on 'official' territory. It certainly proved invaluable for field-work, facilitating informal chats with all grades of staff, including managers. This helped ensure the 'gatekeepers' were kept aware of and familiar with the stages of the research, thus promoting a sense of transparency rather than secrecy. The facility was also important as a venue for staff parties and for the caseload midwives' and mothers' reunion tea, which became an annual jamboree.

The clinical facilities of the hospital were contained within one building, an arrangement that probably contributed to a perception that the medical staff were omnipresent. Apart from the foetal assessment unit, all 'outpatient' facilities and the Community Midwifery Service were on the ground floor; the various 'inpatient' facilities were located on the subsequent six floors.

Two wards and a six-roomed private wing offered inpatient facilities for both ante- and post-natal care, providing an element of geographical continuity for admissions. However, continuity of midwifery carer was minimised by staff being rotated every few months through all departments, although on a highly irregular basis.

Staffing

Midwifery:

Although the hospital's College of Midwifery had been highly respected and the hospital employed a relatively large midwifery workforce, the unit had the reputation for being medically dominated with no tradition of midwifery practice or research. The following section aids an understanding of why the midwifery 'culture' was so weak in this unit. This is an important factor when considering the majority of caseload midwives were trained within or were working in this environment prior to moving into the project; it also aids an understanding of the tensions which developed with the implementation of caseload midwifery.

Management records for 1994 indicated that there were 79 midwives employed within the hospital: 16 G grade (1 part time {PT}) 10 F grade (1 PT), 53 E grades (6 PT). A further 15 were employed as community midwives (14 G, 1 E) and 20 as caseload midwives (10 G, 10 F).

The midwives were predominantly 'white' and many of the junior staff had trained at the hospital. However, with a relatively stable G grade midwifery staffing there was a regular turnover of E grade midwives seeking promotion elsewhere. During this study staffing levels were perceived as becoming increasingly difficult. Initially 20 midwives were re-deployed into the caseload project and, although the evaluation indicated the workload moved with them (Piercy *et al*, 1996), the initial 'teething problems' experienced as the project was implemented and became established contributed to the hospital midwives' perception of being understaffed. This perception became more of a reality as, along with the rest of the city, the unit suffered from difficulties in retention and attraction of staff; the reliance placed on bank and agency midwives was reported to have increased enormously.

Although midwifery management leadership appeared strong, clinical midwifery-practice leadership was almost non-existent. A Research Midwife's post had been created in 1991 but being absorbed into the evaluation of caseload practice, offered no direct benefit to the hospital midwives. At the time of the research there was minimal structured staff development. The majority of midwives had 'certificate' level training in midwifery, a few had diplomas. As the study progressed diploma, then degree level, midwifery students began working on the unit and their more challenging attitude was reported by other midwives as posed a threat to some of the senior sisters.

*"The problem is with the old time sisters who trained a while ago...
Their way was to know Maggie Myles and all that inside out; knew it very, very well"*

"Now there is a 'I've read enough, don't need any more' attitude of the older sisters"

"They count very much on their experience"

"The trouble is that in this hospital no-one gets challenged."

"The new degree students are challenging much more"

"Yes, but you can only go so far. If you want a good time on the ward or want a good report at the end of your stay you will not go further"

(fg.hmE. 04,05 & 06.'95)

Although a budget was available for staff training, and small awards were made through the 'Friends of the Hospital', competition for these was reported. The midwives commonly complained about being unable to obtain financial or time-off support to attend courses or study days and were frustrated in being unable to develop their midwifery knowledge and skills. Some reported considering leaving midwifery because of this lack of interest:

"I don't want to do midwifery I get so despondent. I haven't got a degree and want one; however the university does not have a course to upgrade me, and there is nothing clinically to offer me here. The hospital gives you no opportunities for learning, to grow"

(fg. hmE.12.'96)

Nevertheless, towards the end of the data collection period, this situation had improved. Many staff were attending midwifery modules run at the affiliated university, and several were working towards a midwifery degree.

In-house training sessions were occasionally organised but usually run by medical staff in response to particular requests. These were as well attended as the demands of the busy unit allowed. Midwifery attendance at some of the regular medical meetings was

permitted, and occasionally encouraged. However, staff reported feeling too exhausted to go at the end of a busy shift.

Several of the senior sisters had long experience as practising midwives, but there was no clear leadership with clinical midwifery practice; difficulties encountered by junior staff were commonly referred to and resolved by medical rather than midwifery assistance. Although during personal clinical practice I found staff friendly and helpful, many of the junior midwives reported feeling unsupported, particularly when 'something went wrong', for example, a still birth.

"You don't get the support of the senior midwives.... When you are in charge but newly qualified you should have the support from the DU sisters but it is like you are completely separate"

"There is no ward unity, no real cohesion...People look at what you are doing.....you get blamed if something happens rather than someone sitting down with you looking at what happened and what you could have done differently"

(fg.lm.E12 &13.'96)

On commencing clinical practice I was 'warned' by an agency midwife to "*look out for yourself as they won't*", indicating a sense of ostracism and fear of 'contamination' if a serious difficulty occurred. It was apparent from both informal conversations and interviews held with more junior staff that an element of 'horizontal violence' (Leap, 1997), was experienced by some of the less experienced midwives.

Kirkham (1999) noted how individuals feeling unsupported themselves have difficulty in supporting others, a situation understandable in terms of oppressed groups, where an inability to cope with deviance and a fear of change may predominate (Freire, 1972; Kirkham, 1999). At the commencement of the research there were six midwifery managers over the two sites and a seventh had just left, suggesting that any lack of support was originally not due to lack of personnel. Nevertheless, midwifery management was dramatically reduced when Trust status was achieved and the Head of Maternity Services retired soon afterwards. With such radical changes, the midwifery management was not seen to be in a strong position to support their staff through the period of intense uncertainty that accompanied these changes.

Strong midwifery leadership was provided in the Midwifery Development Centre. However the professor's position was never clearly defined within the SHA/Trust and, with a different university affiliation to the medical staff, her status remained ambiguous. Although a high proportion of the professor's time was spent on site,

particularly during the first two years, close involvement with the caseload project and minimal contact with the hospital midwifery staff, meant she was little more than a figurehead for the majority of midwives.

Although the hospital was famous for research, during the study it was observed that midwifery involvement in this was only important in terms of data collection, usually samples on delivery unit. There was no history of midwifery-led research and the environment was not supportive of the development of midwifery-led care or related research. All midwives were aware of the on-going audit of delivery unit care, but again their input was mainly data entry, which was checked and analysed by the obstetricians. In both units the midwives were seen to be 'handmaidens' to the obstetric researchers rather than active participants in any research process.

With the relocation of the Midwifery College, the hospital midwives no longer had immediate access to a formal source of midwifery knowledge, both tutors and library having moved from the site. A small collection of midwifery books was developed in the different departments but the midwives complained that these frequently disappeared. Use of the RPMS library by the midwives was 'permitted'; however, being medically orientated, it lacked midwifery texts. With such difficulty in accessing midwifery knowledge, in either expert practitioner or text format, invariably the midwives most important source of information proved to be the obstetricians.

The medical staff:

This hospital attracted specialist-trainee obstetricians who were pursuing careers in obstetrics. All the Senior House Officers (SHOs) had undertaken an obstetric position elsewhere, and the reference they obtained on completion of the six month position was reported as being key to their future careers. Many suffered long hours on duty, and tolerated sharp, public criticism of their work without complaint in order to achieve the vital reference. Obstetricians working at senior registrar level were waiting to apply for a suitable consultant position elsewhere. There were usually six registrars (four senior registrars and two registrars) and six SHOs working in the unit on a rotational basis.

Eight consultant obstetricians worked regularly in the hospital, and a further two gynaecologists carried a small obstetric caseload. Unlike the smaller sister unit, the obstetricians in this hospital maintained a high presence, particularly on delivery unit,

checking to see if any of 'their' women were admitted whenever they came into the hospital. In 1994, a part-time consultant was appointed for delivery ward; subsequently little that occurred on the ward passed without their notice. Clinical care considered questionable was swiftly investigated and those concerned castigated. Nevertheless, midwives were reported as frequently seeking advice and support from this consultant.

The medical staffing also included three consultant obstetric anaesthetists, a consultant obstetric-physician and consultant obstetric-haematologist. Five such consultancies was unusually high, particularly the presence of three anaesthetists specialising in obstetrics. The involvement of this department in 'normal' childbirth was confirmed by their input into parentcraft classes where the 'mobile epidural' they had recently developed was reported by midwives to 'be sold' to mothers. All the non-obstetric consultants also enjoyed national and international reputations in their respective fields.

Culture of Care

This hospital had a reputation amongst midwives for being highly medicalised and promoting a strongly medical model of childbirth. Such definitions are usually associated with high intervention rates that are seen as the result of a medical hierarchy promoting an unconsciously mechanistic view of childbirth (Davis-Floyd, 1992). This institution experienced relatively high intervention rates, as outlined in Table 10.

The delivery ward provided a clear interface situation between the midwifery domain of 'normality' and the medical control of 'abnormality'. An understanding of the organisation and ethos of the ward was gained through reflection on personal experience as a practising midwife. However, as tensions between caseload midwives and hospital staff arose at this point it proved an important source for observational data collection. Analysis of both forms of data offered a useful understanding of the culture as practised (Bourdieu, 1977).

Table 10: Summary of delivery outcomes

	1992	1993	1994	1995	1996	1997
No. women	4043	4007	3948	3882	3968	3928
No. babies	4138	4119	4031	3979	4030	4013
SVD	64%	63%	61%	58%	57%	53%
Vaginal breech	1%	1%	1%	1%	1%	1%
Forceps/Ventouse	17%	16%	19%	20%	19%	20%
Caesarean Sections	18%	20%	19%	21%	23%	26%
Elective	9%	9%	8%	9%	10%	11%
Prelabour emergency	2%	3%	3%	3%	3%	4%
In labour	7%	8%	8%	9%	10%	11%
Epidurals	59%	71%	70%	72%	70%	70%
Inductions	21%	22%	22%	23%	25%	25%

Source: delivery unit audit statistics

The delivery ward comprised of a T shaped configuration of two corridors with six clinical delivery rooms close to the staff office along the top corridor and a further four delivery room, a four-bedded admission room, a three bedded recovery/high dependency room and obstetric theatre along the second corridor. The department manager's office, anaesthetists' office, two ex-laboratories used for research and storage, storage rooms and a seminar room were also on this corridor.

Next to a small kitchen was the staff coffee-room used for drink or meal breaks. It was generally extremely unkempt. Although for the use of all staff, the coffee-room tended to be dominated by the doctors, being their main sitting area when on-call for delivery unit. Like the hospital canteen, it was a useful place, a back-region (Goffman, 1959) for people to meet in an informal way, to chat and, to some degree, drop their professional roles. However, from observation of body language and comments made, many of the junior midwives clearly felt uncomfortable when several doctors were present. Nevertheless, the sitting room was the domain of the more junior staff, rarely being frequented by consultants or managers.

Given the strong national movement towards the appearance of 'home-from-home' delivery rooms, those in this unit were unexpectedly clinical. Although spacious and light, the equipment contained in each room was highly visible, minimal effort having been made to hide or disguise it. The delivery 'beds' were high and metal-framed, dividing for lithotomy position; highly suited to the needs of attending professionals but

recognised as extremely uncomfortable for women. Some attempt had been made to facilitate the needs of labouring women; several wooden rocking chairs, floor mats and bean bags were available for use during labour and each room was equipped with a telephone that accepted incoming calls. This enabled couples to talk with friends and relatives, and staff to communicate without intrusion into the room.

The room furthest away from the office, designated as a 'low tech.' delivery room, had been painted with a variety of soft colours and patterns to promote this image. It was most frequently used by the caseload midwives but rarely by the hospital ones; the room's proximity to the office was the main deciding feature in both instances, but for opposite reasons.

Throughout the ward there was a clear demarcation between public and private. Visitors could only access their relative's room; once admitted, women could move freely along the corridors but not into other rooms. Staff however, had free access to all rooms but were encouraged not to enter occupied ones unless caring for the occupant; all staff were required to knock prior to entering an occupied room. This demarcation was generally observed and swiftly corrected if not.

The delivery ward office was the hub of the department. A small, square office dominated by two desks, work surfaces along opposing walls crowded with overfilled notice boards served the needs of those completing notes and the delivery register as well as storage for a variety of books, files, staff mail and miscellaneous items. Two computers and two telephones provided a frequent source of midwives' frustration: lack of access to a functioning computer, and the constant demanding tones of the phone were common complaints.

Although designated as the 'sister's office' the room served as a common meeting ground for all levels of staff working on the delivery ward. A ward-clerk used one of the computers when on duty, and midwives entering delivery data used the other; otherwise it was unusual to see anyone sitting in the room. A third chair was available but occupation of this tended to signify the unit was unusually quiet; the majority of work undertaken in the room was done standing. This was clearly a 'working' office and the door was left open. However, no member of the public was allowed in, conversations being held at the door or skilfully directed away toward their relative's room. This was reported as maintaining the confidentiality of those women admitted to the unit, their

name and certain details being recorded on 'the board' that dominated the office and formed a central co-ordinating tool for the department.

The delivery unit board: aid or control

Use of the 'board' on the delivery unit had been highlighted in interviews with various categories of staff as a problem area with the caseload midwives. However, the crucial role it 'played' in the organisation and ethos of the ward was noted during the observation study undertaken there.

'The board', kept in the midwives' office on delivery unit, in common with other units around the county (Hunt and Symonds, 1995), provided a visual representation of the current clinical workload of the delivery unit. On a pre-marked blackboard details of each woman admitted to the unit were written in the spaces representing each bed; the headed columns both organised the information required and signified what was considered important. A specialised code was utilised to provide an element of confidentiality and clinical details were updated regularly by the midwife caring for each woman. Further information was embedded in the use of particular rooms, providing a clear indication of the activity-level of the unit to the reader with the tacit knowledge (Polanyi, 1958) required to interpret it. For example, a woman admitted to a room considered inappropriate to her requirements, such as the use of the 'low tech' room for a high risk delivery.

During both clinical and research work on the delivery ward all categories of staff were observed to look at the board as they entered the office, apparently seeking a swift assessment of the situation of the unit. This assessment would affect their subsequent behaviour (see box 1).

Assessments of the workload were frequently made from the board in relation to staffing levels: "*four delivered, so you are OK then*" was heard as a statement rather than query made by both managers and doctors. The implicit assumption was that delivered women were no longer important work, thus freeing staff for other work. That the reality may have been otherwise, is an illustration of the different ways of conceptualising birth and the 'work' it involved held by the various professionals.

Box 1:

Observation:

SHO walks into the office at 08.36hrs; s/he is in mufti without a white coat but wearing a bleep. S/he brightly approaches the group of doctors discussing cases, but on glancing at the board, which indicated a very busy period and several problems, mutters 'Jesus!', and joins the group listening carefully.

Field note:

from a brief observation of the board s/he immediately moved from a relaxed social person into a focused professional role

field notes: D.U. observation study no. 11

The most important function of the board was to provide a checklist concerning everyone admitted to the department for use during 'report'. 'Report' took place between medical staff and between midwifery staff at every change of shift, when responsibility for care was handed over to those coming on duty. A summary of each case was outlined by the departing practitioner and, for the midwives, responsibility for care allocated for the shift. Once allocated, it was the responsibility of the midwife caring for a woman to update the board as appropriate.

Such regular updating enable the obstetricians and the sister in charge of the unit to be kept fully informed of an individual's condition, particularly the progress of her labour, without disturbing the mother or midwife caring for her. Perceived 'delay in progress' would be watched carefully by the obstetricians who then proactively involved themselves in care management, before the midwife called for assistance.

Thus the board, or more specifically individual's interpretation of the information presented on it, can be seen to have a direct impact on behaviour and the subsequent workload of the unit. In many ways it was seen as providing a lynchpin for the working of the unit and a medicalised, 'management' approach to labour. This was symbolised in the information that was considered relevant to be written on the board, and actuated through the 'progress reminders' it constantly presented. As such, the board became the focus for some tension between caseload midwives and the obstetricians and sister-in-charge, particularly when the midwives failed to maintain the information on the board, or behave, as expected.

“the doctor came in and was looking down to see who was fully, who was pushing and who wasn’t pushing and why not – and noticed that someone had been fully for a good length of time and why hadn’t they delivered? (they were told it was caseload case and the sister-in-charge did not know) And the doctor said – well, why don’t you know, you’re the sister!”

(i.hme01.'95)

Nevertheless, the controlling influence of the board was clearly recognised and frequently subverted by some of the hospital midwives. The unique physiological timing of a woman’s labour may differ from the guidelines established by the authoritative knowledge (Jordon, 1993) defining ‘safe’ limitations to the stages of labour. Noting events such as the start of the second stage on the board, *“sets the clock ticking”* (a term used by midwives and mothers alike) and a mother not delivered within the allocated time would soon receive medical assessment. However, some midwives prevented such interventions by delaying tactics that avoided *“starting the clock”*, for example, by not confirming the start of second stage when suspected, if maternal and foetal wellbeing were assured.

Many of the midwives complained about the obstetricians watching the progress of labour too assiduously, being too interventionist and expecting women to be examined vaginally two hourly to monitor the progress. Such regularity was not indicated in the procedures manual nor, in personal experience, imposed by the obstetricians. However, during personal clinical practice, I was advised by an experienced sister to undertake such regular examination *“as the doctors expected it”*, a situation also experienced by others:

“Here, if the doctor doesn’t come and knock, in two hours the sisters will, i.e. they are pushing the doctor to ask how things are progressing. To get a breather I give in. OK, come and knock.”

(fg.hm.E04.'95)

This suggested that some of the interventions were midwifery imposed. This may have been a reflection of midwives being slow to change from past obstetric expectations, rather than a particular desire to intervene. However, it is also a characteristic of oppressed groups who adopt the values of the dominant class (Freire, 1972); the senior midwives adopted regular examinations as the ‘good practice’ they perceived to have been commended by obstetricians. In then imposing these values on their juniors, the sisters may be seen to have internalised them as the norm and in conforming rather than challenging, were acting in a form of discipline and self-regulation identified by

Foucault (1977). Thus the ethos of a medical management of labour was absorbed and re-enacted by the midwives on a daily basis and the hegemony was maintained through attitudes and practice rather than any form of domination or coercion. This hegemony was symbolically contested by the implementation of caseload midwifery; the manner in which the midwives were able to contest it in practice forms the main themes of this thesis.

However, a significant proportion of clientele attending this hospital were reported by midwives and anaesthetists as valuing the technology offered, particularly the new 'mobile epidural' pioneered by the anaesthetists in the unit (as reflected in the increased epidural rate between 1992 and 1993, see Table 10). That women may gain a sense of comfort and safety in the presence of technology and may prefer the use of pain relief and equipment to assist their labours has been recognised (Savage, 1990; Davis-Floyd, 1992). The midwives' stereotype of a city business-woman sitting on the bed using her laptop throughout her pain-free labour typified the experience of childbirth for a few of the clientele to this hospital. However, the wider evaluation identified by survey that the majority of women were 'very ordinary' and, for example, wanted to use the minimum drugs they could to cope with pain in labour (McCourt and Page, 1996; Beake *et al*, 2001).

Nevertheless, at the start of the research, it was noticeable that the majority of women remained on their beds throughout labour and that midwives were not proactive in encouraging their colleagues to try the 'tricks' that experienced midwives know can help when progress is slow. In this sense, high medical intervention rates were as much a result of a loss of valuation placed on traditional midwifery skills, as the activities of highly motivated medical staff.

Working in a unit with such a high reputation for medical research, with highly qualified, highly motivated doctors, with minimal midwifery support for knowledge or practice, it could be inevitable that the midwives lost confidence in a midwifery ethos, developing a type of inferiority complex (Kirkham, 1999). The implications of this are developed further in this thesis. Recognition of this factor may help understand why this unit had a reputation for being highly medicalised and promoting a strongly medical model of childbirth, and why the doctors appeared to maintain this position of dominance whilst the 'body' of midwives indeed acted, as defined by some student midwives and Mason (2001), as "*obstetric nurses*".

The Maternity Unit

The smaller of the two maternity units formed a department within a very large, city, teaching hospital, famous for its post-graduate education and research. Close to a large and impoverished housing estate, the catchment area for the hospital encompassed a wide diversity of socio-economic and ethnic groups and was rapidly attracting a large refugee community. The hospital was also an important national tertiary referral centre. Nevertheless, local public transport was limited to a few bus services. The restrictions with transportation and the deprived environment in which the hospital was situated were not helpful features in attracting staff to the unit.

Supporting approximately 1,000 deliveries per year, the maternity section of the hospital served the needs of this relatively deprived urban area. It also provided specialist care for a small number of very high-risk pregnancies, but did not attract a private maternity clientele. The department comprised of an ante-natal and a post-natal ward, delivery suite, Special Care Baby Unit, clinic area, parentcraft room and management offices. Although the wards and delivery suite were grouped with the gynaecological ward on the third floor, the other facilities were scattered around the larger hospital complex. The clinic facilities and the parentcraft room were situated at opposing ends of the main building and the service management and midwifery offices were yet further away. With the Obstetric and Gynaecology Institute building sited in another part of the confusing complex of buildings, the physical dispersion of this department was noticeably in contrast to its sister unit. It appeared to be submerged by, and within, the teaching hospital, and lacked the clear identity and cohesion of the stand-alone maternity hospital.

The facilities were dated and refurbishment was long overdue. The ante-natal ward remained a 'Nightingale-style' unit with two side-wards. When quiet or short-staffed this ward was closed and the antenatal mothers moved into parts of the 22 bedded post-natal ward, which was separated into four-bedded divisions and two side rooms. The delivery ward comprised one corridor accessing three standard delivery rooms, one fitted birthing-pool room, a larger 'clinical delivery' room for complicated cases, three separate rooms for recovery or observation, a designated obstetric theatre and staff office and rest-room cum meeting room. The delivery rooms were smaller than those in

the sister hospital and still relatively clinical in appearance. The Special Care Baby Unit was located on the floor above the delivery ward.

Situated some distance away from the wards and on the ground floor, the antenatal clinic had been refurbished and presented a bright and modern appearance, although it was limited in space and lacking in facilities such as a nursery. The parentcraft room was located on the other side of the hospital; it was spacious but dark and rather gloomy in appearance, natural light being limited by the surrounding buildings.

Staffing

There were 10 G grade, 4 F grade and 27 E grade midwives employed on this site. With limited delivery numbers only a few student-midwives were seconded here. The majority of midwifery and domestic staff were African, African-Caribbean and Asian in ethnic origin. Although the atmosphere of the unit appeared relaxed and friendly, tensions between the groups were reported by junior midwives, and personally experienced, as being disruptive. Without 24hour domestic staff available on the delivery ward, the midwives complained about frequently having to undertake non-midwifery duties such as cleaning. The need to undertake such work caused problems with the caseload midwives who were reported by the unit midwives as frequently forgetting it or doing it very poorly.

Four consultant obstetricians worked in this unit. Three were professors, one working between both units; the fourth consultant worked mainly in another hospital in the area. Their heavy involvement in research and teaching meant that these obstetricians were not preoccupied with the details of clinical care, and were not seen on a daily basis on the ward or delivery unit.

Three registrars and three SHOs covered the department; these positions were not particularly attractive because of the limited experience available. This unit lacked the constant presence of the highly motivated 'career obstetricians' of the sister unit, a situation that allowed a stronger midwifery-orientated culture to develop.

Culture of care

Staff in the unit were acutely aware of the diminishing clientele and that its viability was questioned, a situation resulting from local women being attracted to an easily

accessed, modern maternity unit operating near-by. The relatively poor facilities this unit could offer women in terms of amenities and privacy was clearly recognised.

However, the midwifery manager had been active in developing the 'midwifery' service and a birthing pool had been established on the delivery suite. Although not frequently used, in being able to offer non-interventionist pain relief this helped to promote an ethos of 'normality' and midwifery-led care in labour. Also, a system of team midwifery had been developed to improve continuity of care for mothers and midwives, and to enable midwives to maintain skills in all areas of midwifery practice. Allocated to one of three teams, staff rotated on daily basis to cover clinic, delivery unit and the wards. Based on a ward, midwives would cover their team's clinic sessions as appropriate, and be called to delivery unit when a mother from their team was admitted.

In theory the system was a positive development and appeared to be 'owned' by the senior midwifery sisters. Both sisters and the manager were unhappy with the introduction of caseload practice, considering this would adversely affect their team system by reducing the number of women they cared for. Conversely, the Clinical Director thought that caseload midwifery might 'save' this unit by attracting women who might have booked elsewhere.

Personal clinical practice was undertaken in this unit in 1996 as a way of gaining an understanding of their situation and response to caseload practice. Morale amongst the junior midwives was extremely low. In part, they blamed this on the Team Midwifery system preventing any consistency in their place of work. They reported when working in a particular place the physical layout and vagaries of the permanent domestic staff become known, and confidence and a sense of satisfaction from their work may grow. However, with the teams the numbers were too small for them to do anything but "*staff the gaps*". They moved around on a daily basis, working somewhere different each shift but never knowing where, the place allocated on the duty rota invariably changing by the time they arrived on-duty. Midwives complained they had even worked in all areas during one shift.

Such movement might facilitate the midwives gaining confidence in all areas, but the reality proved the opposite. With minimal continuity in work place and no time to establish confidence there, the midwives were "*surviving*" on a daily basis, never really sure what they were doing or where they would be working.

" I feel like a piece of meat. ... It's just like I'm a number, 'you're a midwife, you go there' ... You do feel a bit de-humanised, as though you don't have anything special to contribute... You're just like the standard unit. You can go here or you can go there. It doesn't make any difference to anyone."

(i.hm023.'96)

Personal experience (see box 2) of chaotic ward management, no-one taking overall responsibility for a particular place, staff arriving at various times throughout the day for short periods of work before moving elsewhere, with no knowledge of what was occurring on the ward, supported the midwives' complaints. A lot of time was spend giving or receiving reports about what had, and what remained, to be done, rather than actually providing care needed. Knowledge about the mothers was limited to a task-orientated approach unless long-term admission had facilitated relationships to develop.

Introduced to improve continuity, the way in which this system was run actually resulted in reducing continuity almost to its lowest level, resulting in extremely frustrated and demoralised midwives. Not only did the midwives report it unlikely that they had previously met a mother they were caring for in labour, but lack of continuity on the ward proved detrimental to ward organisation and care of those mothers admitted.

The example of team midwifery in this unit offers insights into the differences between team and caseload midwifery and an understanding as to why team midwifery may have proved problematic (Sandall, 1997). Like caseload midwives, these team midwives were expected to be flexible and to work in all areas of care on a daily basis. However, they lacked the element of autonomy and control (see chapters 9 and 10) and were unable to anticipate or plan their work, merely responding as directed, being pulled here and there rather like rubber bands.

Nevertheless, the unit held a strong midwifery-led culture, with doctors attending when called rather than undertaking routine rounds. Liaison between the doctors and midwives appeared relaxed and was supportive rather than controlling. Socialising outside of the hospital occurred between the two groups and, at sister level, people related to each other as 'known' individuals rather than professional roles. However, the unit lacked the cohesive agent of the canteen enjoyed by its sister unit, this hospital's canteen being extremely large and serving the needs of several hundred rather

than several dozen. The parent-craft room was used as the venue for staff parties at Christmas, but lacked warmth and a sense of ownership.

Box 2:

Another early shift at the maternity unit. Horrendous!
Ward full – at least that meant no admissions. Wrong. As soon as someone discharged, a new admission immediately came in. There is an inability to mentally plan your work; the unexpected becomes the expected. You always have to prioritise what is essential now, at this minute. Sister on alone. I arrived 8am, 9ish an agency health care assistant arrived; no ward clerk. I gave drugs, sister gave intravenous antibiotics and then report to us both. She couldn't give one drug as the intravenous line was blocked; I drew up the saline flush but saw it unused much later; the drug was signed for but never given. I think she was just too busy to remember. Felt I was running around like a demented dervish. It was embarrassing; I never seemed able to deal with a mother's request because I was always chasing something urgent / answering the phone / sorting out an administrative problem. You begin to develop strategies to avoid becoming involved.

Mary came on to ward "how is it today?" I grinned "this isn't midwifery." She responded emphatically "this is NOT midwifery, this is obstetric nursing!" Sister then went on to work a late shift on delivery unit (i.e. 7.30 – 21.30hrs)

Reflective notes:

The caseload midwives think they work a long and busy day!
Look for these strategies of avoidance in future participant observation.
What do these midwives consider as midwifery?
Consider the 'pace' of activity – differences in way time used in hospital and caseload practice.

Source: reflective notes personal practice Wednesday 24th January 1996

The staff rest room on delivery unit was reasonably sized and equipped with chairs and a television; but doubling as a meeting and seminar room it was not a place where doctors and midwives generally relaxed together if the unit was quiet. Individuals used it for a swift drink or packed lunch, between other usage, and staff met there before going on duty but as a place where the private became separated from the public, its' value was very limited.

Although the relationship between midwives and obstetricians was generally relaxed and responsive, the atmosphere on the wards was more problematic at times. Some of the mothers admitted antenatally for long periods helped give a sense of continuity and stability to the ward. However, they attracted a wide variety of medical consultants who

appeared at any time with a large group of students; many of these were unknown to the midwives. Frequently the only midwife on the ward would be unavailable to immediately join the consultation and it was common for doctors to examine women, write in the notes and then leave without informing the midwife of their presence or instructions. The midwife would rely on the ward clerk, if present, or mother to inform her of their visit. Midwives not being aware of important changes in treatment was relatively common (see box 3). Although benefiting from a positive relationship with the obstetricians, such denial of the midwife's role on the ward by other medical staff, although 'shrugged off' by many, contributed to their sense of being unimportant and devalued by those within the wider institution.

Box 3:

Early shift at maternity unit. Went to delivery unit, told to go to ward until clinic at 9am. Ward very busy (usual). I was asked to give drugs out. Whilst doing this 3 SHOs and some registrars on ward undertaking rounds simultaneously. Chaos. I saw one put some prostin in a lady (to induce labour) but no CTG monitor started. I put one on and told midwife in charge; she had not been told about the prostin by the doctor.

Reflective note: communication between doctors and midwives is very poor – Drs write in notes but midwives not aware. Why is it so bad – this is dangerous?

Source: reflective notes, personal practice Tuesday 23rd January 1996

In many ways one sensed that this unit felt inferior to the stand-alone maternity hospital and that it was fighting for survival. Part of a large city teaching hospital, the smaller unit appeared 'swamped' by the geography of the larger organisation of which it was a part and by the threat provided by the reputation of the larger maternity unit. Lacking the physically and psychologically cohesive features of its sister unit, this department maintained a sense of cohesion through its small numbers and response to perceived external threat. The fear of being overwhelmed by the larger unit, both physically and 'culturally' if they merged on one site, remained an underlying tension throughout the study period.

The context of change - is change

The implementation and development of caseload midwifery did not take place within a static environment but one where uncertainty and tension predominated throughout the planning phase and the subsequent four years whilst data were being collected. It was impossible to estimate how far the caseload midwifery project was seen as a symbol of wider changes or used as a scapegoat for individuals' frustrations and uncertainties, but this was undoubtedly true at times.

Two fundamental changes that occurred during the study period involved the reorganisation of the service in converting to Trust status, and changes in midwifery education.

Service Reorganisations

Less than a year after the project's implementation, the hospital management changed from SHA to Trust status and the opportunity was taken for a major management review, with staff invited to reapply for a reduced number of positions. The outcome of this was a change in remit of the clinical directorate, from 'Obstetrics, Gynaecology and Midwifery' to 'Women and Children's Services', and a considerable reduction in the number of midwifery managers. The original Directorate had been supportive of and closely involved with all stages of the planning and implementation of the caseload project; now the composition of the group was to radically alter. The Clinical Director was replaced by the Deputy Director, the Head of Midwifery retired in the following year and that position changed to one with slightly less power and was not filled for three-four months. The original Directorate Business Manager had already left, but their replacement continued in post following the change to Trust status.

Changes in the higher echelons of the Trust also presented difficulties for the implementation team who had worked hard to get the support of senior management. When this was lost with the change in personnel, difficulty was experienced capturing the imagination of the new team with something already implemented. With fundamental changes occurring within the wider service, the status of a relatively small project remained low on the list of service priorities. Moreover, the turnover in

personnel resulted in a change in management styles, moving from an enabling to a more controlling ethos that limited the powers of the clinical directorate.

Changes in management structure resulted in the withdrawal of a level of midwifery management and the almost overnight loss of several managers who had day-to-day contact with the hospital midwives. Staff were stunned by this manoeuvre and felt this sudden withdrawal of midwifery support very deeply, an emotion which contributed towards the lowering morale of all the midwifery staff at this time.

However, even more fundamental changes were being considered when in 1996-7 the Regional Health Authority reviewed the Maternity Services required in that part of the city. The service provision was to be reconfigured and changes proposed likely to include the closure of the stand-alone maternity hospital. During this period all levels of midwifery staff talked about their feelings of insecurity and sense of vulnerability - despite common sense indicating that clinical midwives would be required whatever the changes proposed and that jobs were unlikely to be lost.

Midwifery education

Changes in midwifery education had less direct effect on the caseload midwives although initially the project was covertly blamed for the loss of the college. Originally based within the site of the stand-alone maternity hospital, the College had moved prior to the implementation of the caseload project, merging with other schools in the area. Within two years, midwifery education had been accorded university status and, with the Schools of Nursing, relocated as an Institute of Health Sciences at the local university. The training curriculum, which had been developed from certificate to diploma, was redeveloped to graduate level.

Although this movement was separate from the caseload midwifery project, the location of the Midwifery Development Centre in what was the college space was perceived by some as the college being 'pushed out' by the project. The hospital had 'lost' its school, and an element of resentment was noticed from some of the midwifery staff.

Planning and implementing the project

Consideration of the planning and implementation stages offers useful perspectives for an understanding of the model development and its reception by those working in the maternity service. These stages were not part of the data collection period and are understood as participants' reflections on the process. Four issues emerged as being central to this phase: the timing, sharing a vision, communication and effort. These are discussed in relation to the 'story' of this period.

The time was right

The importance of timing for effective change is well-recognised (Moss Kanter, 1994; Broome, 1990; Belasco, 1990); in this project the timing was fortuitous. The idea for a caseload midwifery project originated from a serendipitous meeting between the clinical director and the newly appointed professor of midwifery, and the subsequent convergence of their respective agendas: defining a service that maintained its size when relocated to a smaller location, and the establishment of 'midwifery', in a manner that benefited both mother and midwives, within a highly medically orientated environment.

The seed was sown in an environment already prepared for the development of the project. A research midwife had previously been appointed to investigate the midwives' ideas about possible alterations, thus establishing the notion of change. At a national level the Select Committee's report had provoked enormous debate by questioning the current situation and suggesting radical change. The ideas of the midwifery professor, who was a member of The Expert Maternity Group (EMG), were fed into the project planning such that when *Changing Childbirth* was finally published in August of 1993, a model of caseload midwifery based on the recommendations was in the final stages of planning. The national and local political agendas supported the ethos of the project and, merging with the local service requirements, the idea was allowed to gain momentum and the project developed.

Support at all levels was forthcoming, from Chief Executive to E Grade midwife. The clinical directorate agreed the idea as "*an academic exercise*", to be introduced as a

pilot study with a critical evaluation, it being considered that, as the only post-graduate institute of obstetrics in the country, they were in an appropriate position to do this “trial”. The project held a potential political advantage, at no financial cost to the service; any expenses incurred were to come out of the midwifery budget. Nevertheless, discussions with each member of the directorate uncovered a more philosophical underpinning to the support: each individual believed ‘it was the right way to go’ and that mothers and midwives could benefit from the system.

Although the time was ‘right’, the planning phase of the project was reported as being fraught with difficulties and extending beyond expectation. This period was recalled by one as being:

“six months thought about and planned; six month discussed in public, formed protocols etc; and six months dotting the i’s and crossing the t’s”,

(i.co)

whilst another considered it the “worst year” and “quite horrendous” as they recounted the pressures of work and personality conflicts that dominated the situation.

These two accounts reflect very different orientations to the planning; one that was focused on the objective issues concerning management and various procedures and protocols whereas the other recognised the enormous ‘politicking’ and background lobbying essential to create an environment in which all stakeholders would be receptive to the proposed changes. Both were important features, but whilst one was clearly acknowledged and planned for, the demands of the other proved far in excess of expectations. The strength and passion that was needed to guide the ideas through from germination to fruition came from within the Action Group, the small group of senior midwives who were formed to spearhead the implementation, working within the newly established midwifery development centre.

Shared vision

The importance of achieving and maintaining a shared vision of the change (Beckhard and Harris, 1987) emerged as a key feature of the project. Early in the planning stage an ‘Away Day’ for the Action Group was organised and led by the SHA Chief Executive. Members of the group reported an initial reluctance to take time out of busy schedules,

but were unanimous in their subsequent appreciation of its value, particularly in terms of understanding the project in the context of the wider service strategy. Being forced to think clearly and objectively about what they were aiming to achieve, and thus developing consensus and unity of vision, was highlighted in retrospect as a fundamental requirement for the early planning. The mission statement for the project was formulated during this day.

This strategy was subsequently adopted for the midwives interested in caseload practice; a 'study day' was organised for 25-30 "*prospective candidates*" where attitudes, and the philosophy and aims of caseload practice were explored. Twenty eight months after the implementation a second 'away day' was held for the practising caseload midwives; 10 attended, six of the original midwives and four who had joined subsequently. The aims and philosophy of caseload practice were revisited and reconfirmed by the midwives themselves, facilitated by two of the project leaders.

This activity was clearly valued by all parties involved; being asked to take time away from heavy workloads was considered helpful rather than frustrating. However, any success achieved in confirming a joint vision during these days did not negate the importance of frequently re-emphasising this vision to all concerned, particularly as it was reported to be the baseline from which difficult issues could most helpfully be discussed.

Although clarity of vision was shared by the action group team and practitioners alike, the tone of certain documents suggested a degree of conflict within the implementation team, particularly in relation to the degree of medical involvement with 'low-risk' pregnancy. This was confirmed during later interviews with a variety of staff; although the majority understood the outline of the model implemented, concepts of any 'vision' were extremely limited outside of the midwifery development centre.

Communication

In encouraging an inclusive rather than 'top-down' approach to the implementation, the importance of good communication (Broome, 1990) was recognised and carefully addressed by the group during the planning phase, but later acknowledged as a less successful element of their work. All the formal channels of communication in the

organisation were utilised, open forum meetings arranged for the midwives, and a series of regular 'project update' newsletters widely distributed.

Nevertheless, these strategies failed to reach all those intended. Individuals did not attend the meetings, newsletters were frequently viewed as "*just another bit of paper pinned to an overcrowded board*" and, most seriously, information failed to reach the majority of the GPs who referred to the service, despite using their recognised communication system. When information was sent personally, the GPs complained they had not been consulted, and formed an agitation group - a situation which took sensitive negotiations to defuse and nearly jeopardised the project. A GP 'panel' was then established which met regularly until the project had been running for nearly a year.

Individual face-to-face contact proved the most successful form of communication, both in attracting midwives to the project and, if points of potential resistance could be identified, in "*picking them off individually rather than as a group*". Informal communication mechanisms also proved highly reliable. Those who were interested informally sought and obtained what proved to be accurate information. However, those resistant to the change avoided information, choosing not to read or even to misinterpret information provided. Successful communication required an active and positive reception (MacDonald and Hearle, 1984). However well-planned the communication mechanisms utilised, information provided was clearly interpreted according to an individual's personal agenda, and various strategies then used by them to seek, or alternatively avoid, further clarification.

Change appeared more readily accepted when positive pre-existing relationships, particularly those of trust, were built upon. The consultants in the smaller unit were reported as presenting little opposition and a manager suggested they "*didn't notice the caseload project arriving*". Conversely in the larger unit, where the directorate system was relatively new, the proposed change generated a lot of questioning. A member of the Directorate noted that there was "*no outright coherent opposition, a bit of sniping*" which needed "*explaining and reassuring rather than persuading*", but it took much longer to reach an acceptance.

Overcoming such reluctance took its toll, and support within the implementation team was crucial to maintain the energy and fight. When tired and seriously questioning the

wisdom of the project, a manager noted how, being called at home by a consultant one Saturday morning with the comment: “*You’ve got to go for this project. And if it fails so be it. Try it.*” re-vitalised their spirit. The encouragement given was based on years of trust and mutual support gained from working in the same unit. Once the possibility of failure was acknowledged and accepted, the energy to continue and succeed was forthcoming.

Recruitment

Many of the caseload midwives reported learning about the project through personal contact by a member of the planning team. This approach was adopted to “*test the water*” to ascertain if any midwives would be interested in the idea of working this way. It is possible that only ‘likely’ candidates were targeted but this strategy appeared to have contributed to the impression, later vocalized by several hospital midwives, that selection was biased towards specific individuals.

General information meetings were held on the wards at regular intervals and a register of interested midwives was formed; 20 midwives registered, ten of whom eventually became caseload practitioners. The response of one midwife, when asked how she learnt about the project, illustrates how their knowledge about the proposals gradually built up over time:

“Really through word of mouth, Y (a member of the implementation team) spoke to us on night duty in the very early stages and explained about the whole project. ... I remember thinking oh yes, yes, yes, yes yes here's another, another thing we have to consider but will it... I was very doubting at that time. And then as word of mouth got round, different people were interested and there was more information and the newsletter came round explaining more. I began to be interested in it, particularly from the fact that you were going to be practising fairly autonomously and giving continuity of care. And also the money. ... It was an opportunity to go for, for another grade. ...(though) I think I would still have gone for it if it had been an E anyway.”

(i.pm01)

Prior to selection all candidates were invited to attend the ‘Awayday’ meeting previously mentioned, held on one site. This was promoted as an ‘attitude workshop’, run by a recently retired senior midwifery tutor. The aims were to discuss the intended philosophy of the project, help ensure those selected were aware of the implications of caseload practice, and that all were going to work with a similar ethos of practice.

Interviews were held during the early summer months of 1993, and a consumer representative was invited on the selection panel. The selection requirements included a mandatory 12 month clinical experience but focused more heavily on demonstrating an understanding of recent policy changes with the maternity services and aspects considered important to modern maternity care, such as evidence-based practice. Individual characteristics and personal skills were also important as flexibility and ability to work in a team were fundamental requirements. It is probable that the more recently qualified midwives would have felt most confident with this focus; and in general the successful candidates were fairly recently qualified, a situation which gave rise to much discontent and concern expressed by the senior midwifery sisters. A profile of the midwives selected is presented in chapter 6 when focusing on the nature of their experiences.

At that stage the project had still to be finalised and, rather than confirm appointments, those selected were referred to as "*successful preferred candidates*". This state of uncertainty was to become an enduring feature of the project.

The effort

Although implementation of this project was led by individuals experienced in change management, and the desire to change was identified at all levels of the organisation, even with a strong and committed force behind the project, the planning and implementation stage was never easy, nor success certain. Despite an enormous amount of time and energy committed to the work, implementation of the project was not assured until a very few weeks before it actually occurred. The precise timing of the implementation was less a response to being fully prepared and more an acknowledgement of a continually changing situation and recognition that if they did not "*make the leap*" they never would.

The caseload midwifery project

Project mission statement:

*“To seek ways of promoting excellence
in midwifery practice which provide an individual service
to women and their families, respecting their rights,
beliefs and values.”*

As indicated in their mission statement, the aims of the caseload midwifery project were twofold: to improve midwifery practice and to improve care provision for mothers.

The organisational features of the model were outlined briefly in chapter 1, as summarised in Table 2. All midwives had been recruited from within the service and the development was undertaken within the constraints of the original midwifery budget; no extra funding had been made available.

Table 2: Organisational features of caseload practice:

- | |
|---|
| <ul style="list-style-type: none">• 20 midwives, working in partnerships of 1G & 1 F grade, within groups of 6/8 individuals• each providing ante-, intra- and post-partum care to 40 high- and low-risk women giving birth per year• offering midwifery-, GP- or obstetric-led care in community or hospital |
|---|

To facilitate the re-deployment of staff without extra funding, the pilot project was set up to serve one local neighbourhood.

Management and administrative support

As this model of care was completely new, extra support was considered important during the implementation phase. Also, the majority of midwives had no experience of home births or waterbirths, both of which were to be facilitated if requested. In view of the expected educational support required, a lecturer-practitioner was appointed part-time to the project management team as well as a full-time clinical manager. These positions involved a re-negotiation of the duties and responsibilities of current employees rather than newly funded appointments. Both carried personal individual caseloads and, as well as meeting the managerial and educational needs of the midwives and later the student midwives who were seconded into the project, they facilitated and supported midwives with home deliveries.

The 'Action Group' of five experienced midwives was central to the planning and implementation of the project; the group comprised of the midwifery professor, maternity services manager, project manager, lecturer-practitioner and researcher-practitioner. These senior midwives also provided 24hour backup availability for both clients and staff, and met weekly to review progress. After the initial few months, the 'on-call' cover became unnecessary and was discontinued although the group continued to meet regularly with the three midwifery group practices.

Resources

The caseload practitioners were allocated a 'midwives' office within the larger of the two units, the maternity hospital, and an administrative secretary worked for both the project clinical manager and evaluation team.

Each midwife was allocated a lease car, if required, and repayment of travel expenses contingent on the monthly submission of completed 'mileage forms'. The bills from the use of the mobile phones were carefully monitored and midwives were expected to reimburse the SHA for charges incurred during personal use of their phone. The expectation was that 'land' phones would be used where possible to minimise costs. As each midwife worked where and when required rather than cover fixed duties and on-call rotas, a standard settlement was negotiated in addition to their salary to cover the hours potentially worked at night. Thus the completion of unsocial hours and extra-duty payment forms was no longer relevant.

The project was designed as a two-year pilot study. Changes that were made to the service as it became established and eventually absorbed into the mainstream service are outlined later.

The Start – November 1993

Joining the project one-week after it had commenced it was clear that the initial period was one of excitement and apprehension; as one of the Action Group noted, everyone would be relieved after the first 'successful' delivery. The unit was pervaded by a sense of anticipation and of fear. Questions were raised – would it work? What risks were being taken? Would the midwives be able to cope?

"I had always said to (another member of the implementation team) I'm not sure the midwives will actually do this when it comes to it. ... I think the first six months were terrifying to be quite honest. You know, I'd look at the midwives and they looked so tired and I'd think – what have we done to them? ... And then there is always this fear of a terrible clinical error at that stage. I mean, you know it happens with the hospital service, but if it happens to you at a crucial stage it can destroy the whole thing."

(i.AG01)

It was feared that a 'false' move on anyone's part could jeopardise the project.

During the first few days midwives identified their caseloads and began "*selling themselves to women*". Sorting out the basics such as transport, and equipment were important, as was getting used to the mobile phones – in an era when these were not commonly used. Initially the mobile phones presented difficulties for everyone. Lack of experience and the novelty factor generated massive bills at first; also at times women experienced difficulties contacting their midwives and this proved a major source of irritation for hospital midwives who were contacted instead.

"There was an element of selling ourselves; initially we had to persuade women into the service when we were getting our caseload from the conventional service. I felt like an insurance salesman".
"Now we can say (to mothers) this scheme has been working for four years, then it was 'I've got a mobile phone which you can contact me on' (but I don't know how it works!)."

(fg.om.pm12 & pm13)

However the atmosphere quickly settled down and the midwives were seen less in the hospital as their caseloads developed and the workload increased.

Many of the difficulties experienced during the initial stages involved organisational issues, in particular, defining and establishing ways of working and necessary policies and procedures. Finding space to work, for example in a busy clinic (eventually one room was allocated to the midwives), and completing apparently vast quantities of necessary paperwork were common complaints. No longer enmeshed within an established system, the midwives found that the administrative support normally provided by ward and clinic clerks was absent; new mechanisms for standard administrative procedures such as filing of laboratory tests needed to be defined. Until they were the caseload midwives had to undertake these tasks as well.

Two of the major difficulties for the midwives centred on factors that would later be resolved: working between two very different hospitals, and the use of the hospital-held client notes and traditional co-op card. Handheld notes were eventually adopted Trust wide and proved an enormous benefit for this model of care. Until then the midwives made their own notes and transcribed these into the hospital set whenever they remembered, - a situation which caused problems on several occasions and involved unnecessary duplication of work.

Constantly needing to define their role to other colleagues was reported by caseload midwives as an essential yet irritating feature of the early days and the political nature of their work proved a surprise to them all. These issues are discussed in more detail when focusing on staff responses to the project.

Caseload Midwifery – the lived experience

An understanding of how the midwives worked is helpful in order to contextualise the themes which emerged from the analysis and are discussed in subsequent chapters. This is a brief description of the way the model, outlined earlier, was ‘operationalised’ by the midwives, following through the course of working with women from booking to postnatal care.

Women living in the catchment area either self-referred to the service administrator or were referred by their GP. In group practice meetings, the midwives co-ordinated the management of their caseloads, with each booking a balanced mix of women (including different levels of ‘risk’) across the year, working around planned leave, to care for 40 women giving birth.

In time, clients presenting with a subsequent pregnancy contacted their previous midwife directly. Nicknamed “*re-offenders*” these women were usually warmly welcomed, being slipped in as an ‘extra’ if necessary, in recognition that bookings for another month could be reduced accordingly. The midwives described previous clients as being easier to care for as a relationship was already established and much known about the family; they appreciated the opportunity both to see the family again and to see the development of the baby they had previously assisted to deliver. Even when the outcome of that pregnancy had been negative in some way, the midwives considered

their subsequent involvement beneficial as they could offer appropriate midwifery care, given their detailed knowledge of the family's particular circumstances.

Once referred, women were contacted by a midwife, either by phone or letter, to arrange a partial 'booking' at home; during this visit they were offered the choice of care and care-leader. Choice of 'lead professional' tended in practice to be dictated by her level of 'risk' and, whilst the majority elected for caseload midwifery, a few women preferred full hospital care and were subsequently moved over. GP involvement was influenced both by the woman's preference and her own GPs views and levels of interest in maternity care.

All women were asked to attend hospital for a medical examination and dating scan but the provision of subsequent antenatal care was determined by the mother's choice and clinical requirements; where possible it was provided at home. Initially, the 'standard' format of visits was adhered to, but the midwives eventually adopted a reduced minimum schedule for 'multips' (Hall *et al.*, 1980; DoH, 1993; Sikorski *et al.*, 1996) with an emphasis on women's preferences as well as clinical requirements. For women with obstetric risks or complications, the caseload midwife worked closely with a consultant obstetrician, continuing to provide as much of her care as appropriate, at home.

Women who required hospital admission during pregnancy received care from the hospital staff during that time, although their 'own' midwife would visit to co-ordinate care and discharge. However, it was usual for the caseload midwives to undertake any inductions required by their women, with back-up support from hospital-based staff.

Initially parentcraft information was provided individually by each midwife and women were invited to join the hospital parentcraft classes if they wished. However, in recognition of the value of peer support for the pregnant women and friendships that might be formed at such meetings, community-based classes were later developed and run by the caseload midwives.

Apart from their arranged appointments, women were able to contact their midwife at any time for advice and assistance. However, to avoid undue disturbance, the midwives learnt to "educate" their women about appropriate contacts. Appreciation of this formed an important feature of the midwives' transition into caseload practice; once

established, they reported that they were rarely called at night except for labour or an emergency. This is contrary to the commonly held perception that being 'on call' meant that being called was inevitable. Analysis of midwives diaries indicated that despite being officially on call in many cases on alternate nights and weekends, midwives were called out for an average of 5.4 hours per week during 'unsocial' hours (McCourt, 1998).

Although they initially found the requirement to be available, and the presence of the mobile phone, unsettling and intrusive, most quickly learnt to relax until called. One midwife noted how she found her mobile phone very reassuring, enabling her to relax at night knowing that her women could, and would, call her if they had a problem.

Usually women phoned their midwife once they suspected labour had commenced. The midwives quickly learnt how to assess a situation over the phone, deciding whether it was more appropriate for them to visit the mother at home or meet her at hospital. As they became more experienced they tended to care for more low-risk early labour in the home, moving to hospital once it was well established. Towards the end of the study period when midwives were more confident in home deliveries they talked about making the decision for actual place of birth during the labour, although this had not yet become established practice.

Initially the midwives aimed to provide intrapartum care for almost all of their caseload; the target set was 75% and some achieved 100%. However, they recognised that this was not sustainable and the majority modified their practice to ensure that women were familiar with their midwife's partner (Beake *et al.* 1998). In this way, they learnt to avoid the "long hauls" which without support would tire them out, without compromising continuity or quality of care. Recognising this, combined with early tensions with some hospital staff who perceived the midwives as providing a separate 'elite' service, ironically, helped to bind the midwives into a cohesive group who learnt to be mindful of each others' situation and offer support, relief or sustenance as needed. Consequently, partner and group support formed a crucial feature of their practice. Nevertheless, whilst most women were happy with the care received provided they had previously met the carer; it was the midwife who appreciated being present at delivery and felt cheated if unable to be there.

Following a normal delivery mothers were encouraged to return home as early as appropriate, most of the care required in hospital being provided during visits by the caseload midwife; more complicated situations demanded closer liaison between hospital and caseload staff. This situation remained difficult throughout the study period, with mothers themselves reporting to the evaluation team problems they had experienced on the postnatal wards (McCourt *et al*, 1998), although a later, follow-up evaluation indicated that such problems had been resolved (Page *et al*, 2001).

Postnatal care was continued at home by the caseload midwife, selective visiting quickly being established as the norm. From informal chats with the midwives, rather than formal data collection, it became apparent that the midwives valued being able to review the labour and delivery with their women, to have the opportunity to talk about what had occurred as well as assess treatment or advice given. They felt continuity of carer had particular benefits for the midwife in enabling care provision to be both enjoyable and, by facilitating prompt feedback, informed; such lessons were considered harder to achieve within the conventional service.

Discharge from midwifery care took place between 10 to 28 days post delivery. However, as this involved the ending of a relationship that had developed in intensity over eight or more months, several of the midwives reported finding this difficult on occasions, although all had quickly recognised and developed strategies to avoid the mother becoming dependent on them. Although the professional link was terminated, some midwives reported occasionally re-visiting a family if they were in the area and invitations to birthday parties or christenings were mentioned with delight. It was clear that caseload midwives were able to form very different relationships with mothers they cared for from those they had formed when working in the conventional services.

Student Midwives

Student midwives were seconded into the caseload service after the initial six months. There were several developments of the student midwives' curriculum during this period, both in terms of the movement to Diploma and then to Degree status and also the development of a course that was more in-line with Changing Childbirth. Initially the students were offered a place with caseload midwifery for their elective; then in 1995 the course was designed so that the final six months was spent with a caseload midwife.

Student midwives were allocated to work with specific midwives or partnerships. Although unable to follow mothers through from booking to post-natal discharge, they were encouraged to develop their own 'caseload', ensuring these visits did not coincide with university commitments and that, wherever possible, they were present for birth. Students who had personal transport were able to undertake more work alone under the guidance of their caseload midwife; those without relied on their midwife to 'ferry' them between visits. Students reported appreciating the greater experience of holistic care and more responsibility they were given in caseload practice. Many of their responses paralleled those of the caseload midwives, although the students clearly did not have 'ultimate' responsibility and worked under the guidance of their midwife.

The implications of these changes for the hospital midwives were such that fewer students were working in the hospital at any one time, and when they did their attitude was both questioning, in response to degree level education, and following their secondment into the project, observed and overheard as slightly disparaging towards the hospital midwives. Having experienced caseload midwifery, many of the senior students reported in the focus group interviews, as perceiving the hospital midwives to be functioning as "*obstetric nurses*". As they were not necessarily tactful in the way they expressed their views, as overheard in the 'coffee room', it is likely that this perception was made known to the hospital midwives.

Subsequent project history

An understanding of the project's history is helpful in order to appreciate the constant tension the caseload midwives experienced concerning their future job security. At the time of writing this thesis caseload practice is being extended to cover much of the local service (2001/2). However, its status was not so assured during the life of the study and data were collected in an environment of enormous uncertainty.

The project had been conceived as a two-year pilot study, the continuation of which would be considered in the light of the evaluation results. Midwives were given temporary contracts, and no arrangement was clearly defined concerning their position should the project be terminated. Most caseload midwives were promoted on joining the project and they perceived their higher grade would be withdrawn if the project was discontinued.

Although at the end of the two-year period the project was continued, being partly absorbed into the mainstream service, the midwives constantly received mixed messages and never felt reassured. The promised 'upsizing' to the 24 midwives that were necessary to meet the demand of the area was never fulfilled. This resulted in a permanent over-demand for the service, the need to refuse people and to form a 'waiting list' in the event a space on someone's caseload became available. The service was successful and popular but the promised extra resources were never forthcoming.

The results from the evaluation had proved positive but wider considerations about the future profile of the maternity service dominated management agendas. Concerns were focused on the planned closure of the stand-alone hospital and the role the new unit would be expected to assume. The Health Authority's reconfiguration of the maternity needs of the wider geographical area, served by several hospitals, considered various formulations in which caseload practice did not necessarily feature.

At the end of the data collection period the caseload practice manager was being removed and the midwives were expressing grave concern as they considered the implications of the way they worked were not fully understood by any of the midwifery managers then present, a situation confirmed by this study. The unexpected issues they met, such as long term sick leave or maternity leave were dealt with as per the conventional service. This caused enormous problems for the midwives, frequently necessitating them to assume a much larger caseload until 'permission' for a replacements was obtained and the lengthy procedure of advertising, selecting and appointment completed. There was a clear need to circumnavigate the bureaucracy on occasions, particularly when filling unexpected gaps in staffing, something that had been overseen in the past by the project manager. Once that position was removed the caseload midwives felt un-represented and without authority in a system of management in which they had little trust.

Despite these organisational difficulties, the caseload midwives reported gaining enormous job satisfaction from working with the mothers, the sources of which will be explored in greater detail in subsequent chapters. What they found more problematic were the reactions of the other midwives and obstetricians to caseload practice, particularly the responses of individuals who had previously been their colleagues that they found hurtful. These will be explored in the following chapter.

Chapter 5

THE PROFESSIONALS' RESPONSES

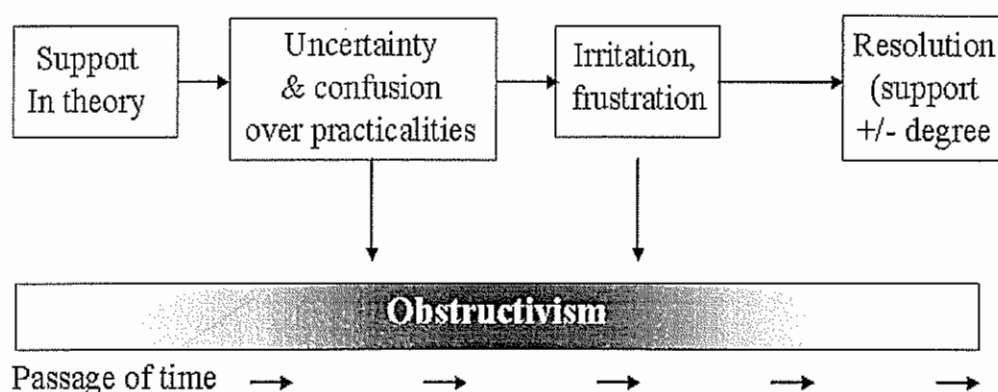
"Change is never easy. There will, naturally, be some who oppose it."
(*Changing Childbirth*, DoH, 1993:71)

Caseload midwifery was not implemented within a vacuum but a busy, highly medicalised maternity service. Nor were the caseload midwives working in isolation, but as part of a team that included and relied on the obstetricians and hospital midwives. The reactions of these professionals clearly affected the way the project was 'allowed' to develop and their support or obstruction framed the experiences of the caseload midwives.

Given the recognised demoralisation in midwifery and the increasing pressure on obstetricians (McKee *et al*, 1992), the project might have been welcomed and supported. However, initially a degree of obstruction prevailed, reflecting both difficulty with change in an environment of uncertainty, and a sense of marginalisation for both midwives and obstetricians. Although their reactions were somewhat similar, their situations differed and will be considered separately. Nevertheless, a general pattern to the responses was apparent, as outlined in Figure 1.

Response pattern

Figure 1: general responses to implementation



The majority of respondents were supportive of the aims and objectives of the project. Both midwives and doctors were aware of problems with the conventional service and recognised benefits the project held for women. However, both groups expressed

concern about the demands it would put on midwives and doubts were expressed about their ability to work this way. The only group expressing a negative attitude toward the model was the community midwives.

Ideological support was followed by uncertainty and confusion. One of the features of working within the highly structured and hierarchical organisation of the hospital was the clear definition of roles, responsibilities and ways of working; ambiguity and confusion were minimised. In contrast, the project was implemented with a responsive rather than controlling management ethos, and minimal imposition of pre-determined, and possibly inappropriate, 'rules'. Although during the planning phase guidelines such as referral criteria had been negotiated in response to obstetricians' concerns, the project management encouraged the caseload practitioners to find solutions to problems they encountered. Clear leadership was occasionally demonstrated but, by encouraging a 'bottom-up' rather than 'top-down' approach, the inevitable teething problems took time to be resolved. This gave the impression of a lack of organisation and control that contributed toward the sense of uncertainty and confusion experienced by hospital staff.

Reactions to this situation were commonly negative, ranging from mild irritation to serious frustration and, on occasions, outbursts of rage, although those most seriously disrupted by the project did not necessarily demonstrate the greatest negative responses. Personal characteristics, such as adaptability to change, and positive ideological support of the project may have tempered negativity. For example, the senior midwives involved with the interface situations of Delivery Unit and Clinic faced daily frustrations yet in general they maintained an overall positive attitude. Nevertheless, strong management support for them was essential, with the project manager being sensitive and responsive to the difficulties they experienced.

Two other issues helped fuel negative responses. Firstly, the caseload midwives, in attempting to hide their initial fears, inadvertently antagonised by projecting an image of confidence and creating an impression of superiority; an impression enhanced by a slightly aggressive and demanding attitude, rather than the assertiveness they developed with experience.

The second irritant was the sense of elitism concerning the project that hospital and community staff identified. This was generated partly by the initial image and attitude of the caseload midwives, but also by the realisation that this was a positive service

development which benefited only a limited number of women, albeit a relatively deprived group. Appreciating the positive sides of caseload midwifery only served to reiterate the problems of the conventional service. Both medical and midwifery staff highlighted the inequality the project engendered, particularly in relation to some women having their 'own' midwife, and not needing to 'wait their turn' in clinic.

Negative responses diminished as the service settled, - pathways becoming established, uncertainly replaced by routine and disruptions lessened; however the sense of inequality of service for women remained.

Acceptance and tolerance developed over time, but such resolution did not yet involve a real incorporation. In the majority of cases, as the project became established and appeared 'here to stay', people figuratively knuckled under and got on with their work, accepting it to a greater or lesser extent as one part of the overall maternity service. Negative reactions, such as unhelpful attitudes and comments, were still reported four years into the project but these were confined to particular individuals rather than a general response.

The degree and duration of the responses outlined above were very individual, but the pattern was common.

Midwives' Responses

Although implemented to improve the maternity services for women, *Changing Childbirth* presented an opportunity to develop the profession of midwifery, changing midwives' boundaries of responsibility by reclaiming normal childbirth as their province, and realising their role as autonomous practitioners (UKCC, 1998). Although the majority of midwives did not choose to carry a caseload, support for their colleagues who accepted the challenge to test the new system might have been expected.

The reality proved different. Caseload midwives found their midwifery colleagues unsupportive and, on many occasions, obstructive. Moreover, those that were interested noted they did not want to join caseload practice because they '*did not want to be hated by their colleagues*', indicating an underlying atmosphere of antagonism.

The midwives responses are considered in two distinct groups, the community midwives and the hospital midwives, the data suggesting each group was differently affected. The community midwifery service provides a contrast against which to assess caseload practice, whilst the hospital midwives' perceptions highlight some of the problems experienced at interface situations.

Community Midwives

Of the staff who participated in the ethnography, this group was unique in expressing highly negative views concerning caseload midwifery, understandable given the project held no positive benefits yet had direct practical consequences for them. More significantly, by replacing rather than involving the community midwives, caseload practice presented a fundamental devaluation of their work.

Talking with the community midwives 15-18 months after the project implementation, negative attitudes towards the caseload system and practitioners remained prevalent. There was a strong sense of them still coming to terms with the changes imposed and threat presented by the project, presented here as the explicit and implicit consequences.

Explicit consequences

The community midwives reported the implementation of caseload midwifery fundamentally altered both the organisation and content of their work.

With the loss of three midwives and a geographical workload 'patch' to the caseload project, the community service was reorganised and two teams created from the original three. The change said to be imposed on, rather than negotiated with, them and for some this *"felt like a family unit was broken up"*.

This distress was compounded by changes to the composition of their workload and the perception that they had lost precisely the feature that caseload midwifery promoted, continuity of care, when those previously working in the postal areas allocated to the project had their 'patches' redefined. Familiarity with an area and the long-term relationships established with families were important sources of satisfaction and fulfilment; as one midwife described, she would *"see these ladies day after day and see the fruits of my work daily"*. Long-term continuity had now been destroyed as mothers

were no longer able to call on community midwives who had delivered their previous children.

Loss of a 'patch' cultivated over years of work, and being forced to work in a less familiar area, establishing new relationships and networks, generated considerable resentment, and the anger of some individuals were reported as being vocalised loudly within their department. Moreover, their distress was compounded by having to provide some care in the area, limited funding preventing the SHA from appointing the 24 midwives required to cover the entire area allocated.

'Our impression was that in the area ...selected they would give total care. ... We felt hurt, especially when, even though that area was gone, we were still in there and working even harder than ever in that area.'

(fg.cm.'95)

The community midwives conceived that they were 'filling in the gaps' left by the caseload midwives, particularly in terms of parentcraft and difficult cases:

"The manager said that project midwives will prepare their mothers for birth but they come to our parentcraft classes!"

General agreement on this.

"I had a class of 7 and found that only 2 were mine, 5 were project. I didn't mind but I was shocked."

(fg.cm.'95)

Nowadays they don't take people with problems, they drop them, now seem to be creaming off. They are very selective and also take from out of their area.

Yes, that's just the word... 'Creamed-off' patients.....There is selective patient care only, the rest is left to us.

(fg.cm.'95)

In the community midwives' view, the caseload midwives selected 'low risk' mothers, leaving the 'high risk' ones for them (not confirmed by audit). This was said to have affected the community midwives' scope for offering 'Domino' care, offering intrapartum care for women in hospital:

It (the project) has affected, our number of Dominos has dropped dramatically and the amount of postnatal care we do had increased plus, plus, plus.

(fg.cm.'95)

This perception reflected the altered composition of the community midwives' workload. The degree of continuity they provided in ante- and post-natal care was reported to have reduced as the project stopped 'midwives clinics' in GP surgeries and

many GPs now provided some care to antenatal mothers. Consequently a higher proportion of community midwives' work was delivering postnatal care to women they had not met before. The 'dilution' of their patch also had the consequence that, in caring for a more scattered population, they reported travelling further and were more heavily tied up in the traffic problems of the city.

The one situation where the two services interfaced involved the sharing of equipment for home deliveries; these had been relatively infrequent events and it had not been considered justifiable to duplicate the equipment. This was stored in the Community Midwives Office, collected when called to a home confinement and returned immediately afterwards. However this sharing of items had generated problems, as indicated by one of the managers:

"...the other time when antagonism comes out is over the wretched equipment...I thought about having our own set but I'm dead against it, I think it's a terrible waste of money But things like - oh, you know, when entonox cylinders are left by the door (not replaced correctly) - that, that sort of business. No, it's a real no no. (laughs) The eighth deadly sin!"

(i.AG04.2'97)

Implicit Consequences

Perhaps more significantly, the development of caseload midwifery was seen to pose a political, psychological and economic threat to the community midwifery service. It undermined the traditional community midwives' position by seemingly devaluing their work, and contributed towards their sense of job insecurity.

Aware that the project was implemented within a context of larger organisational changes, the community midwives foresaw the demise of their service as they currently delivered it. A sense of inevitability, that they would be forced into carrying a caseload, was expressed. Caseload practice had originally been rejected because of the uncertainty of the project or for personal reasons, usually related to family commitments:

Researcher: "How did you hear about the project and what were your reactions?"
"Insecurity not knowing. There were many whispers, we (maternity hospital) were going to close, our job position was insecure. I had just had a child and could not imagine working that way."

(fg.cm.'95)

"At first we had the impression that the community midwifery service would stay as we were and would amalgamate into the caseload service. (Then,) Do we apply for jobs or slot into the project? It was very frightening, People kept asking are you applying? The big thing was... are you doing the right thing if we didn't apply? Would you have a job if you didn't?"

(fg.cm.'95)

"We still feel very insecure, this hospital is closing, what is going to happen. There are 20 caseload midwives and only 14 of us. When the new hospital is built will we have to reapply for our jobs?"

(fg.cm.'95)

The community midwives' sense of insecurity was further undermined by the implicit devaluation of their work and experience, demonstrated by the model itself and during the planning of caseload practice. They felt completely rejected. Although having years of experience in the community areas targeted, they reported that they not been involved in any of the planning and any potential input was rejected:

"X was our manager of community services, she was extremely experienced and had a lot of experience in this style of service from the past. She raised issues at the information meetings and was told to shut up..... It felt as if she was pushed out so we knew that our ideas would be ignored as well."

(fg.cm.'95)

Three community midwives had become caseload practitioners, forming the key leaders for each group, but the perception was that they had been specially selected and others not encouraged to apply. One other who did apply was told her application had been received after the closing date.

"The attitude was 'we want to make a new start with a clean sheet', not (use) midwives set in their ways... Didn't ask our advice at all. 'Your type of care we don't want'."

(o.no.3.cm.'95).

Their bitterness was compounded by the perceptions that they had tried to introduce new practices within their own service, but these had been rejected as too costly. An alternative duty system that facilitated increased continuity of carer but involved more on-calls and the use of mobile phones was cited as an example. Nevertheless, monies not available for them were then found for the caseload midwives - who were provided with equipment the community midwives had long requested but been denied:

"What they got when they started off we've never had and still don't have – sonicaid, briefcases, telephone and bleep – all equipment. Recently we said: 'Fine, they have briefcases, why can't we?' Then Y (manager) pressed for it. When it started off they were 'The Queen', with us as existing midwives – we had to be begging and begging, even for our safety."

(o.no.3.cm. '95).

The perception of being treated as 'second-class midwives', was reinforced by the reactions of women they cared for:

"Because of the patient's charter and the caseload project, patients realise they can chose what they want, they can demand what they want. This affects us because we cannot give them what they want."

"It is difficult to explain as they think we aren't capable of providing the same kind of service"

(fg.cm.'95)

The level of their demoralisation was summed up in the comment:

"I feel we have been forgotten as human beings. They (and we) are trying to improve the service but we have been forgotten as human beings. The public are not aware of it."

(fg.cm.'95)

Discussion

Such responses should be understood in relation to the context data from the previous chapter. The ethos of the maternity service was very hospital orientated and clearly it had not supported a thriving, active community midwifery service. Although more autonomous than hospital midwives, the community midwives remain confined by duty rota, on-calls and a pattern of prearranged clinics. Such constraints minimised flexibility and encouraged a particular and fixed relationship with their work, notably to provide a structured service rather than a responsive one that met the needs of women.

Although limited, so used with caution, observation of the community service supported this view. Their work was observed to be very focused, directed towards meeting the clinical midwifery needs of ante- or post-natal clients. Other needs, such as collecting an urgent prescription for antibiotics from a GP, even when identified (as acknowledge during a later chat in the car) were not addressed on the pretext of being too busy, in this instance with a clinic to attend. The danger of 'setting a precedence' and 'women taking advantage of the midwife' were cited as reasons not to depart from a clinical

focus. Such responses draw into question the nature of midwifery work as it was perceived.

The community midwives clearly felt threatened by the introduction of caseload practice, and for reasons which are readily understood. Nevertheless, negative attitudes toward change are influenced by personal expectation and experience. Senior midwives in this unit tended to view the community service as a somewhat stagnant 'backwater'; providing a 'G' grade niche for midwives who were not career orientated and who exhibited little motivation to change practice. However, these midwives reported minimal power to influence any changes in their work.

Their negative attitudes and reluctance to embrace change may be understood in terms of the responses of an oppressed group (Freire, 1972; Kirkham, 1996, 1999) whose perspectives were denied, with consequential loss of initiative, and low morale and self-esteem. In such instances, the group cannot 'develop', and the ensuing tensions tend to result in 'horizontal violence' within the group (Kirkham, 1999; Leap, 1997). Although organised to work as part of a team structure, and exhibiting unity in their concerns about caseload practice, in practice the community midwives admitted they tended to work in isolation. An atmosphere of disunity and friction was reported by student midwives and managers as commonplace within the community midwifery service and a sense of harmony and mutual support was not apparent when personally working with them.

It was apparent that several of their responses were factually incorrect, although it was difficult to determine if these were genuine mistakes or reflections of particular attitudes. For example: much of the equipment used by caseload midwives had been bought personally in response to a perceived need, eg. sonicaids. This mistake is illustrative of community midwifery being seen as an 'occupational group' rather than 'profession' (see chapter 9); with minimal motivation to 'invest' in their work, their attitude reflected the more structured 'contract' ethos of their service in contrast to the responsive one of caseload practice. This 'contract' ethos was also apparent in the management rejection of their proposed continuity scheme, due to their inability to overcome the higher costs incurred in their inflexible duty-rota and on-call arrangements.

Their responses to the implementation of caseload practice could be considered as the reaction of a basically powerless group who recognised that change was indeed inevitable.

Hospital Midwives

Caseload practice presented more practical problems and less of an ideological threat to the hospital midwives; working together, tensions at this interface were clearly recognised.

In line with the pattern of responses outlined in figure 1, hospital midwives expressed positive views as to the ideology of caseload practice, identifying the benefits to women of having more trust in the midwife, and midwives having more responsibility, getting to know women so helping them more appropriately, and increased job satisfaction:

“it allows the midwife to fulfil her true role as a midwife...It’s marvellous”.

(i.hmG01q)

Concerns were expressed about midwives’ abilities to work ‘that way’, ‘on-calls’ and safety issues being highlighted in particular. Also, caseload midwives being ‘put upon’ and the service proving a cost cutting exercise to the detriment of the midwives was raised. It was suggested that, given their increased responsibility, all caseload practitioners should be G grades, like community midwives.

Although supportive of the project in principle, the majority of midwives interviewed did not wish to undertake caseload practice themselves, citing impending retirement or movement, family commitments, desire to maintain a social life outside of midwifery, and lack of experience as major reservations. Nevertheless, rejection of caseload practice did not indicate they placed a high valuation on hospital work. A comparison between the nature of hospital and caseload midwifery was reflected in one midwife not applying because:

*“I’m thinking of moving out of London and I would feel easier in my conscience just leaving an **ordinary** hospital job at short notice than leaving a **proper** job - if you’ll forgive me saying so, - at short notice.”*

(my emphasis) (hm.E01q)

A comment perhaps reflecting the occupational as opposed to professional status of the hospital midwives. Analysis of the hospital midwives' reactions to their work (not presented here), revealed extreme discontent in line with the findings of Robinson (*et al*, 1983; 1989, 1990) Chamberlain (1996), Kirkham (1999) and others.

Whilst individuals expressed a positive attitude towards the project, there was also a lot of uncertainty. People did not know how it was going to work, how it might impact on their ward, and how it would affect them personally.

Concerned was expressed that this was the way forward and that they would either have to eventually join in or lose their jobs, a perception involving an implicit devaluation of the work they were currently doing. Short staffed and perceiving themselves extremely overworked, such a belief only added to their already demoralised spirits:

"the fact that if you didn't join it you were seen as though you were stuck in the hospital and that was not the greatest place to be for a midwife because you were totally being overrun by doctors - which is not true".

(i.hmG04)

Minimal involvement of the hospital midwives in the planning stages was interpreted as a rejection of the experience they could offer, particularly their knowledge of 'suitable' midwives. The selection process caused anxiety and some distress when midwives considered suitable were rejected whilst those selected were considered both clinically and managerially inexperienced, many of whom were known and been taught as students. Both antenatal clinic and delivery unit sisters were aware of the potential for, and reality of, mistakes being made, particularly in the early days; senior midwives expressed deep concern about their responsibilities when in charge of a department where the caseload midwives practised.

"girls who had very little experience were going out to join the project and coming back in with caseloads when we knew that the majority of them - definitely the F grades - had very little experience to deal with problems they were facing. And it was a very worrying period of time, because you knew in your heart and soul that you were going to be on the labour ward the night that they were on and you were the one who was going to have to pick up the pieces. And that was very worrying. So I think, really, the selection could have been a bit more ... should have been a bit more strict and I'm sure looking back on it ..."

Researcher: "Stricter for what?"
"For experience"

(i.hmG04)

Concerns identified involved clinical issues such as antenatal advice given to parents, and problems with antenatal blood tests, thus mirroring the initial concerns expressed by the caseload midwives themselves. It became clear that concerns focused on a few midwives, not all, particularly those who did not ask for advice or assistance.

Initially, tension and some conflict were generated by misunderstandings about how the system worked and the division of responsibilities. Midwives complained that things kept changing and information altered, causing further confusion.

The hospital midwives understood that caseload midwives were responsible for 'all care' for their women, even when admitted to hospital, a misperception apparently perpetuated by some senior midwives and confirmed by the behaviour of some of the caseload practitioners:

"on the ward there was a 'do not touch!' we were told not to touch patients because they were caseload, It came from both sides – I got my fingers burnt with a caseload midwife saying 'don't touch my women'".

(fg.anc.'95)

This situation took a long time to resolve. Nearly four years into the project women still reported being ignored by hospital staff, and students talked of finding lack of care to 'their' clients, for example, post caesarean section: soiled beds not changed and over-full catheter bags not emptied.

Such neglect of basic midwifery was initially a result of confusion over roles and responsibilities, and later of poor communication. However, over time it may have become both an expression of territorialism and a response to the hospital midwives' perception that some of the caseload midwives were lazy, avoiding the boring work, and behaving more like visitors to the unit than midwives at work. This perception proved particularly annoying when the unit was busy:

"And it used to really annoy me to think that we've seen them coming in just visiting ... where we were running around like mad, mad fools."

(i.hmG04q)

"It's the attitude e.g. bed making – come in see lady but walk away and her bed was just left"

(fg.hm'96)

"I've never seen one of them make a bed!"

(fg.hm'96)

These complaints mirrored those raised by the community midwives when they talked of the caseload midwives ‘*creaming off*’ the low risk cases, but in this situation it proved an immediate irritant to the already harassed hospital staff:

“I just felt that for a lot of the time they were coming in visiting - not really, really doing continuous care as such. We were taking over the bits. We were taking over the problems - like breast feeding ... that was just so annoying. They used to just come in, brief case, phone - you know, here I am - anything for me - and walk off the ward if there wasn’t. And it used to really, really bug us down. Honestly. We were so annoyed.”

(i.hmG04q)

Situations were open to different interpretations. Junior midwives reported more negative views to come from the sisters; e.g. when a caseload midwife was delayed getting in to care for a woman in labour, arriving when delivery was imminent, the hospital midwife noted:

“But the midwives in charge... said - well, that’s just typical - you’ve done all the work and now she’s going to come and get the delivery. And that was the attitude, whereas I hadn’t viewed it that way at all”.

(i.hmE02/3)

On recognising the caseload midwives needed help with women admitted to hospital, the hospital midwives reported being willing to assist. However, clear instructions were not always provided and confusion frequently arose, causing un-necessary work:

It is upsetting when you have done all the care, particularly when it is busy, and then they come in and say ‘I’d have done that’. (citing a demonstration baby bath)

(fg.hm’96)

The staff reported being upset when the caseload midwives initially communicated directly with the mother, especially when they had been involved in resolving a problem for the mother as it indicated a lack of recognition of their input:

They come in and immediately communicate with mother not us – e.g. problem we’ve dealt with, ‘Yes I know, the mother told me’. It puts your back up”

(fg.hm’96)

Such comments illustrate where primary responsibility or allegiance is given, reflecting the change in caseload midwives.

Clear instructions were valued as confusion generated extra work for the hospital midwives; some caseload midwives were considered “*brilliant*”, but most were not. Inconsistencies in caseload practitioners’ expectations were recognised. For example, induction of labour where some wanted to be phoned with the results of an assessment, whilst others got annoyed at this interference. Over time, they got to know who liked what – a situation that they likened to the consultants, which contributed towards their sense of inferiority:

the trouble is that the hospital midwives are being used and abused.

(fg.hm’96)

This perception was a thread that ran throughout the conversations and is summarised in Table 11.

Despite complaints the midwives “*don’t come in to do the nitty gritty*”, hospital midwives considered the caseload system worked if mothers went home early. They recognised not everyone wanted this, despite encouragement from the caseload midwives, and that organisational features, e.g. delays with the paediatrician’s baby check preventing mothers being discharged from delivery unit, necessitated ward admission and caused the hospital midwives extra work.

Although the economic evaluation indicated work moved with the midwives and that the length of stay was reduced (Piercy *et al*, 1996), the hospital midwives perceived the project had increased their workload. This may have been due to the ‘time lapse’ between the start of the project and the caseload midwives functioning efficiently, during which time the hospital midwives were put under extra pressure in helping sort problems out. Also, during the subsequent years, jobs were frozen due to the impending re-organisation. A heavy reliance was placed on agency staff, whose unfamiliarity with the local geography, system, and protocols, caused extra strain on the hospital midwives, particularly those in-charge:

“Taking people out of the system. Forced to use more ‘casual staff’ – unfamiliar with our routine therefore much more pressure on people in charge. Freeze on staffing. Constant pressure contributed to people leaving”.

(i.hmG01)

Table 11: Uses and abuses - hospital midwives' complaints

<u>Clerical tasks</u>	expected to pull women's hospital notes for use on delivery unit – caseload midwives phoned in and expect hospital midwives to have them available by time they arrive with the women. This stopped with the introduction of hand held notes.
<u>Clinical tasks</u>	eg. undertake the daily foetal monitoring on antenatal ward. care on wards eg. making beds, breastfeeding problems preparing a mother for operation (caseload midwife goes straight to theatre) admit women if they arrive unexpectedly in delivery unit (an initial problem which improved over time)
<u>Equipment:</u>	they take things and do not put them back (thus stopping others doing their job) <i>"If something is missing everyone says it's caseload midwives!"</i> Not clearing up: they leave their room & equipment very messy
<u>Personal issues</u>	they were untidy; left personal possessions lying around. unprofessional – some dressed sloppily. Identity passes not clear; new midwives and students a particular problem
<u>Blocked resources</u>	use of computers, of phones and clinic room. <i>"There's not just one but 20 of them!"</i> This held others up.
<u>Held up system</u>	delay in getting 'bookings' back into system if caseloads are full, slower - took longer time to book women (blocked room) blood results slow to get into notes – collected – needed filing
<u>Communication</u>	<i>"We are always on phone trying to get them."</i>
<u>Mediation:</u>	having to act as 'go-between' – consultants not understanding or didn't listen or understand properly. Consultant putting moral blackmail on client & sister had to explain again. Part-time consultants would shout and cause a problem in clinic whereas the full-time knew where to go to effect change or complain

Inevitably the caseload project was 'scapegoated' as being partly responsible. They also presented a daily reminder of an alternative:

"They came and they looked after their one and only patient and you almost thought - look at that, just the one patient to look after and I've got Mrs ... , I've got the..., I've got to go to theatre, take two sections .. And they looked nice and fresh and you know, the whole, um, profile was so glamorous. It was so nice, wasn't it?"

Researcher: "Really?"

It was lovely, lovely. And so you then thought - why doesn't she clean her room properly? Look at the monitor. Look at the But again, that's human nature, I think. It's just a degree of jealousy, I think".

(i.hmG01)

Perhaps because of the perception that caseload midwives enjoyed a more positive profile, hospital midwives were quick to cite problems with the service or mistakes that had been made. Many of these were a result of a new system being worked out 'on the ground', initial difficulties which were overcome once the caseload midwives organised their work effectively. For example: women were reported as not knowing who their caseload midwife was, or complained to hospital staff about waiting a long time in clinic for their midwife to arrive. Other problems considered by hospital midwives as leading to poor care involved hospital notes not updated, a situation resolved with the introduction of handheld notes, and blood result forms not immediately filed but seen to pile up.

Concern was also expressed that the caseload midwives did not always follow standard procedures and the suggestion made that they occasionally took risks. Practices such as *"having no second midwife present at delivery"*, *"not having syntometrine available for a physiological 3rd stage"*, and *"leaving students with women in labour, telling them to call when 9 cms. dilated"*, were cited by hospital midwives as examples and defined by them as *"dangerous and unsafe"*. Such comments reflected the way these hospital midwives' tended to follow established routines unquestioningly instead of applying knowledge to specific situation. In the situations identified caseload midwives were considered to be *"take risks in the name of progressive midwifery"*, although such practices are the norm for other units (personal experience).

Knowledge

Obstetrics as the 'authoritative knowledge'

Knowledge has long been recognised as an important source of power. For Parsons (1949), functionally specific knowledge to which there was controlled access formed a major contribution to professional authority. A less structuralist approach taken by Foucault (1980) highlighted the role discourse played in the distribution and control of power. Foucault considered that power worked through discourse to shape popular attitudes towards phenomena. Expert discourses were established by those with power or authority, and countered by those with competing expert discourses. Thus discourse may be used as a powerful tool to restrict alternative ways of thinking or speaking, and knowledge becomes a force of control (Giddens, 2001). In reporting her study of information-giving during labour, Kirkham (1989) warned how midwives even lacked the language appropriate to midwifery; the discourse was medically framed and constituted in a manner that denied the reality experienced by mothers and some midwives, for example the notion of 'transition' in labour (Kirkham, 1989:134-6). Similar linguistic omissions denying the more 'feminine' skills involved in nursing, and the importance of 'intuitive' as opposed to theoretical knowledge, have been raised in feminist analyses such as Davies (1995).

As outlined in the description of the context of the study, access to and control over the 'discourse', or authoritative knowledge (Jordan, 1993), of childbirth formed one of the principal sources of medical power in the conventional service, constituting the hegemony of the unit. Over time knowledge proved a source of power for caseload practitioners, and they began to develop a heresy to the hegemony (Davis-Floyd, 1999) in offering an alternative approach. However, as the majority of caseload midwives had trained within this environment, gaining confidence in thinking and practising in alternative ways took time to develop.

In the hospital one of the main reasons for the medical domination of the service, as described in the context chapters, was their knowledge base. For career-obstetricians working in a recognised centre of excellence, knowledge acquisition and generation was fundamental to the doctors' work. This contrasted to the relatively weak body of midwifery knowledge that was available and enacted within the hospital. Although a number of midwives had been practising for many years, as both Schön (1983) and

Benner (1984) noted, experience does not necessarily indicate expertise. Unlike the medical staff, the senior midwives worked as managers and were not actively involved in teaching or research. The lack of midwifery expertise, in the form of a role-model or library, and the lack of a forum, formal or informal, for discussion or development of midwifery knowledge further impeded this situation. Midwives were seen to be 'treading water' just to keep abreast of work, as opposed to actively reflecting on practice and developing their expertise. As an established practice, doctors rather than midwives formed an important source of knowledge acquisition for the midwives. These features, summarised in Table 18, contributed towards obstetric knowledge being the authoritative basis from which all staff worked.

The development of a medical dominance of knowledge was, in a Foucauldian sense, colluded with by the midwives. Pressure of work, lack of midwifery confidence, and with no strong leadership to the contrary, the hospital midwives became very skilled in particular areas and adept with the technology. In effect they had become, as the student midwives defined them, "*obstetric nurses*". This description did not apply to all the midwives, a few of whom were strong in 'midwifery'; but the corporate body of midwifery knowledge was weak and midwives did not strive to overcome this, a situation similar to that found by Kirkham (1989).

The perception held by many of the midwives that the doctors, as experts in obstetric knowledge, knew best was exemplified in the situation described in Box 5:

Box 5

Personal experience: A senior registrar was explaining a new research protocol to the midwives who were expected to implement it. Several ambiguities became apparent to me during the explanation. However, when as an E grade midwife I sought to clarify these, a senior sister 'quietened' me reassuringly with a gentle hand on my arm saying "*shush, he knows what he is doing, he knows best*".

Field-note comment: Although the potential for compromising the research data was clear to me, a 'doctors know best' attitude dominated. Why? Because they were perceived to have authority and be experienced in research? How far does the exercising of such perceptions over-ride good practice in other aspects of care? What inhibits a 'team-work' attitude in such situations?

Source: reflective practice notes; delivery unit; 1996

**Table 18: Knowledge development and the practitioner:
structural and motivational features**

Features of knowledge development	Doctors	Hospital Midwives	Caseload Midwives
Motivation for knowledge development	Career orientation. Clearly defined career structure. Expectation of training. Highly motivated.	Very limited career structure. Professional requirement but minimal check. Personal interest. Limited motivation.	Personal involvement and responsibility for individual care of caseload. Direct feed into care. Strongly motivated
Ease of local access to knowledge	Medical library on site, with librarian & computer resources. Senior colleagues active in lecturing and research.	Access to on-site medical library. Occasional midwifery texts held on wards. Senior colleagues in management; active midwifery lecturers not on site (apart from L-P with project). Ready access to obstetricians.	Personal control over time and space facilitates accessing university midwifery libraries or personnel, as desired. Lecturer-Practitioner initially attached to project.
Structured learning arrangements	Regular medical seminars and presentations.	No regular in-service training. Ad hoc seminars arranged. Invited to some medical meetings. Attendance at meetings limited by shift hours and pressure of work.	Group peer-review discussions. Facilitated to organise seminars as need identified. Attendance at these enabled by personal control over work arrangements.
Knowledge generation through research	Career focus or expectation of training. Active involvement in selection, design and process of research.	No requirement. Involvement through data collection for medical staff and for audit. No involvement in selection, design or analysis.	Active involvement as participants of major research project requirement of job. No involvement in design or analysis.
Focus of knowledge development	Medical aspects of childbirth. To become experts in field of obstetrics.	Medical aspects of childbirth. Care of women in hospital. Become skilled 'obstetric midwives'	Holistic aspects of childbirth. Care of women per se. Become skilled midwives.

Challenges to the hegemony

Nevertheless this tendency towards unquestioning acceptance was not universal and appeared to diminish over the course of the study. The impetus for this change was likely to be from two sources: the presence of degree-level midwifery students with a more questioning attitude, and the developing confidence of the caseload practice midwives offering an alternative source of expertise.

The centrality of university education for professional status was noted by Talcott Parsons in 1937 (cited in Bryan, 1999). However, as Kirkham (1996) detailed, a body of 'midwifery' knowledge had yet to be formalised, and much had already been lost. As this was slowly being developed, from the anecdotal and experiential to research-based knowledge, the new midwifery degree curriculum drew heavily from obstetric and sociological disciplines. Nevertheless, critical analysis was integral to both diploma and degree level courses and, familiar with much of the current evidence, the new students began to question practice, particularly that which was not research-based. Initially this generated some irritation amongst the more experienced midwives but over time students helped influence a change in attitude and became accepted as a useful source of knowledge. This was most noticeable in caseload practice where, particularly towards the end of their six-month secondment, during observation of the group meetings students were seen to actively participate and were both seen and heard to be valued as contributing members of the team.

The students' university-level knowledge base was particularly helpful in challenging inconsistent aspects of the hegemony. The national impetus for research-based practice promotes the image of an exact science, rather than the reality of 'shifting sands' with research-based knowledge being 'the best at present' and often contested. Nevertheless, even where evidence was considered strong, a lack of medical agreement on certain issues was apparent; for example the timing of induction of labour following spontaneous rupture of membranes or for post-maturity. Some consultants disagreed with the hospital guidelines and demanded different policies be followed.

Whereas such inconsistency had previously been 'explained' by the hospital midwives as the idiosyncrasies of particular consultants, it became apparent that these were increasingly being questioned, in private if not directly to the individual concerned. Some of the caseload midwives were particularly vocal, questioning amongst

themselves why particular consultants were "*allowed to get away with*" adhering to practices which were not "*up to date*". A 'theory:practice' gap was identified by midwifery students in medical as well as midwifery practice. Although the students were not well placed to challenge senior obstetricians, and merely complained in frustration, such practices were increasingly called into question by the midwives, particularly the caseload practitioners who learnt to defend changes in their practice with clear arguments and research-based evidence.

Developing caseload knowledge: a new source of power

Although originating from the generally subservient position of midwives outlined above, over time the caseload midwives' knowledge base became very different. This affected their attitude and the sense of power they demonstrated.

All the caseload midwives identified an enormous increase in their knowledge, highlighting their initial steep learning curve as they gained experience and constantly exercised their skills in all areas of midwifery. This way of working forced them to translate theory into a practical application in a way that made sense to themselves and their women. An understanding of individual circumstances caused them to 'situate' their knowledge, they had to 'apply' it, to contextualise it, and in so doing they gained a greater understanding of the issues involved. In doing this they were also able to learn from mothers, as suggested by Kirkham (1996).

Moreover, the midwives had the motivation to seek out knowledge in their desire to provide good care for 'their' women. Personal control over their work gave them greater flexibility than their counterparts working in hospital in their ability to find information; not tied by time or place they could visit the university library or meet with particular 'experts' during their working day.

Knowledge development was supported by the philosophy of the unit in which the project was initially based; admitting to not knowing something was considered acceptable if addressed. Midwives were encouraged to identify their learning requirements and their access to appropriate resources was facilitated rather than 'delivered' to them. The importance placed on peer review in the job descriptions was to encourage a 'learning from each other', with the aim of developing their body of midwifery knowledge.

The sense of responsibility engendered by 'owning' a caseload, control over working arrangements, and the facility to be responsive and reflexive rather than merely reactive, offered the caseload midwives greater opportunity to develop their expertise and achieve the 'expert' status defined by Benner (1984). Also, this enabled them to develop an 'authoritative knowledge' (Jordan, 1993) in midwifery practice that had not been developed within the community midwifery service.

The change in attitude and knowledge that was demonstrated by the caseload midwives generated both resentment and respect amongst their colleagues. Resentment was expressed mainly by those with minimal power themselves, in particular the junior doctors and 'junior', although experienced, hospital midwives. More senior medical staff initially considered the caseload midwives to be *'bit above themselves'* but over time accorded them some respect, and reported valuing the midwives' input into the planning of care.

This change in attitude partly reflected the development of trust and an acknowledgement of the caseload midwives' competence. It was also recognition of the midwives developing and displaying a sense of authority concerning the mothers on their caseload; an authority that was derived from the autonomy and responsibility exercised and knowledge they had developed. Nevertheless, this authority was not 'given' but 'earned', and most effectively exercised where trust had been established, as identified observing the doctors' round on delivery unit (see chapter 5).

Trust

Trust is an essential characteristic for successful working relationships (Kirkham 1999) and was identified as a sub-theme in the analysis of this study.

The centrality of trust in post-modern society was highlighted by Giddens (1990), who considered it fundamental to even the most basic of activities such as going upstairs or driving a car; trust becomes important when information is absent. In the maternity service trust appeared to act as the vital lubricant that enabled the smooth working of a complex system involving a number of practitioners. For caseload practice this was observed in several ways:

- ***Doctor to midwife:*** 'Testing' of midwives was both admitted to by a senior registrar and noted as a common feature during the observational study of the

doctors' delivery ward 'round'. Presentation of a succinct and relevant summary of the case by the midwife, with an outline of a clear plan of action, often resulted in a cursory visit and the midwife and mother were left alone. Inappropriate or lack of response on the part of the midwife resulted in them being watched with care and medical involvement in the case was likely.

Senior doctors, who tended to remain on site for a number of years, got to know the caseload practitioners quite well and reported quickly deciding who to trust. The more junior doctors, who rotated frequently, rarely learnt to know the caseload midwives; several appeared to hold the system, and midwives, in some apprehension.

- **Midwife to mother:** Midwives reported that, in learning to trust mothers they were then able to relax more. Trusting that women could and would call if they had a problem, and trusting women to be able to give birth normally were important features of the equality of relationship formed. The midwives also learnt to trust themselves and that good care did not necessitate constant action (Menzies, 1970; Benner, 1984). They reported that on occasions their greatest action was in deciding when not to act, particularly during labour, but remain quietly aside and 'allowing' the mother to continue as she wanted. This form of action through 'inaction' was considered extremely difficult at first, reflecting the original philosophy of 'management' of labour where some form of intervention was the norm. However the midwives learnt to trust the value of their 'being' rather than 'doing', their 'presencing' (Benner, 1984; Fleming, 1998) as an important constituent of good midwifery care.
- **Mother to midwife:** Midwives expressed surprise at the time it took women to disclose personal issues such as previous abuse. This suggested that trust was not an inevitable part of the relationship, however close it appeared to be, but needed to be worked at. As women knew their midwife better they revealed more about themselves, and so empowered the midwives to provide more appropriate care.
- **Midwife to midwife:** Trust in each other proved an important feature of the partnership and group practice. Knowing their partner worked in a comparable way, and that when not present appropriate care would be given to their women, enabled the midwives to relax when not 'available'. Problems occurred if the partnership worked in very different ways or when relationships broke down within the partnerships or group.

As the vital lubricant for a service where all parties were over worked, everyone needed to learn to trust each other. In caseload midwifery, a sound knowledge base and reliability remained essential yet it was also imperative that individuals earned the trust of their colleagues and clients and worked to maintain it. Once gained, trust proved an empowering feature of the midwives' practice.

Professionalisation of the oldest profession

An ill-fit

Acknowledgement of the degree of autonomy achieved and the development of a specifically midwifery body of knowledge demands consideration of viewing the implementation of caseload midwifery as a form of professionalisation of midwifery (Sandall, 1996). This view is slightly ironic given that midwifery has been conceived of as 'the oldest profession', emerging as an essential occupation that developed as bipedalism evolved (Trevathan, 1997).

As Freidson highlighted, the various analyses of 'professions' present such confusion and contradiction that any sense of unanimity of meaning is "*more apparent than real*" (Freidson, 1977:15). Nevertheless, the occupation of midwifery which developed since the 1902 Act fitted Williams' (1993:8) summary of the key characteristics most commonly cited; these included:

- skill based on theoretical knowledge
- the provision of training and occupation
- tests of the competence of members
- organisation
- adherence to a professional code of conduct
- altruistic service

Moreover, it is Friedson's (1977:23) additional criteria of a profession being "*free of the authority of others over their work*" that, on a day-to-day practice basis, clearly separates midwifery from nursing. Officially and legally, midwives are stated as being autonomous practitioners in the realm of uneventful, 'normal' childbirth. This position had been undermined by the hospitalisation and increasing medicalisation of childbirth,

as discussed in chapters 3 and 4, but caseload practice enabled midwives to reclaim that competency. This contrasts to nurses who are bound into an occupationally subordinate position to doctors; although having claimed many 'professional' attributes they remain, in Friedson's terminology, "*paraprofessional workers*" (1977:25). On this basis it could be argued that caseload midwifery has claim to 'true' professional status.

However, midwifery, and caseload practice in particular, sits ill with the ethos of the traditional professions. These have a masculine orientation (Hearn, 1982) and, although purporting autonomy of practice, as Davies (1995) highlighted, they require major input in the form of preparation and servicing in order to function. Usually this is provided by the more 'feminine' occupations, such as secretarial work or the semi-professions (Etzioni, 1969) like nursing. For Davies (1995), the dilemma for the professionalisation of nursing, and by extension midwifery, lay in this gender orientation and its denial of the 'feminine' nurturing features that form the basis of caring work.

Moreover, a further criticism of traditional professionalisation suggests the demands of the occupation itself may take precedence over the client. In her consideration of the medical profession and the work of the General Medical Council (GMC), Stacey (1992) criticised the restrictive and defensive practices that led to doctors putting the profession before the public. Such questionable prioritisation, as acknowledged in the Bristol Inquiry (Diamond, 2001), lead to public outcry and cause great distress.

In condemning the GMC as an outdated 19th century phenomenon adhering to a set of "*collective illusions*", Stacy (1992) considered the need to address the lack of insularity and secrecy that, under the guise of confidentiality, cloaks the majority of professional consultations. She also suggested that the idea of a one-to-one relationship with patients needed to be relinquished in recognition of the contribution others make to health and healing (Stacey, 1992), a movement which might also decrease patients' vulnerability (Atkinson, 1995). The warning holds resonances for individual midwifery caseload practice, although the problem was addressed by the importance the midwives themselves placed on working collaboratively as a result of their experience.

More central to the debate lie the issues of the nature of professional knowledge and the power relationships involved with its generation and protection.

It is widely accepted that 'expert knowledge', as a systemised theoretical body of knowledge, is the essential foundation on which professional status is built (Parsons,

1949; Freidson, 1977). The theoretical basis of this knowledge is rationalism, a belief in scientific objectivity, that knowledge can be certain and absolute, and has status and origin independent of humans (Popper, 1972). Yet knowledge is not absolute, but socially constructed and changes as new information is discovered (Williams, 1993; Chalmers, 1982).

Control over the focus of knowledge development has, until recently, been held tightly in the domain of the relevant experts or professions. There, bias of personal interest or patronage can influence the acceptability of new research proposals and allocation of limited funding, successfully dictating the agenda and focus for knowledge development in that field.

As Williams (1993) commented, although there is no one 'ideal type' of profession, and they may change over time, a key element of the professional-client relationship is one of 'mystification'; professionals promote their services as esoteric. In laying claim to their specialist knowledge, professionals offer a prescriptive service; they know better than their clients, prescribe what the client needs to know, and, in passing on that information, expect compliance as well as a degree of recognition and respect from their client (Friedson, 1977; Hugman, 1991; Williams, 1993).

Creating dependency on their skills and reducing the areas of knowledge and experience they have in common with their clients, enables professionals to increase the 'social distance' between themselves and their clients - and so gain increasing autonomy (Johnson, 1989). For Atkinson (1995) the asymmetry of the relationship is exaggerated to the point that the client becomes not the beneficiary but the *victim* of the consultation (author emphasis). The power base of the professional is affirmed.

These concepts of 'objective knowledge', 'mystification' and 'social distancing' are at complete variance with the ethos and practice of caseload midwifery. As previously discussed, the uniqueness of each woman was recognised in a relationship between midwife and mother based on the exchange of information. Mutuality and interdependence was stressed with the midwives striving to promote independence rather than dependency in their clients.

Aligning midwives with traditional professionalism would undermine the essence and strength of their work. Moreover, traditional professionalism is increasingly being questioned (Schön, 1983; Giddens, 1990), and there is a developing lay involvement in

‘expert’ knowledge evaluation and generation. The traditional position of the professional is under threat.

Development of the ‘lay-expert’

A growing disenchantment with the claims of ‘grand experts’ and ‘absolute truths’ was noted by Giddens (1990) and been demonstrated in public disputes over ‘experts’ advice concerning ‘BSE’ and genetically modified foods. Concurrently, an apparent diminution in the power of professionals, particularly doctors, has been introduced with the development of a consumer and managerial culture in welfare provision (Mason, 1995). Changes in policy have been designed to give more power to ‘clients’, and make services more efficient with the development of managerialism and the purchaser:provider contracts. The power of professionals who provided the services have been contained to give users of the welfare state, ostensibly, a greater voice in how it is run. This has been extended to an involvement in research undertaken on NHS premises with the co-option of lay-people on NHS research committees (SAGCI.in NHS.R&D, 1998).

A “*democratisation of science*” (Bloor, 2001) offers the potential to tackle public priorities, address public mistrust, and enrich scientific thinking by the incorporation of diverse perspectives (Irwin, 1995), thus challenging the ‘gate-keeping’ practices of professionals in knowledge acquisition - a situation the internet has helped achieve. ‘Lay expertise’ has developed in a variety of areas and, at times, challenged the professional orthodoxy (Bloor *et al*, 1998), occasionally becoming accepted as the scientific orthodoxy (e.g. Miners Lung and pneumoconiosis, Bloor, 2000). The co-presence of medical expert and alternative expert should, Bloor (2001) suggested, increase the effectiveness of clinical decision-making. Nevertheless, the degree to which lay influence is achievable within a professional forum has yet to be established.

Childbirth offers a contrasting perspective on the development of lay-expertise. Reliance on professional advice should be minimal for healthy women undergoing a normal physiological process. However, ‘lay’ expertise built up over the millennia has, in the last century been appropriated by the professions (Kirkham, 1996). Childbearing women in modern society are further disadvantaged by lacking experiential knowledge about childbirth. With fewer pregnancies and the majority of deliveries ‘hidden’ away in hospitals, women have minimal experience compared to their multigravid counterparts in resource-poor countries. They also have a major emotional investment

made into their one or two planned pregnancies, with an ensuing heightened desire for perfection (Giddens, 1999). Although successful childbearing does not necessitate medical intervention in the majority of cases, mothers are forced to seek professionals' assistance to access the resources of the NHS and social service benefits, and almost invariably couples turn to experts for advice and guidance.

It is in this slightly unusual environment, where 'normality' has been forced into a reliance on the professions, that a counter movement has developed (Ashton, 1992) and received subsequent governmental support, in their acceptance of the recommendations of *Changing Childbirth*. Increased consumer involvement in care is now standard government policy.

Nevertheless, Bloor (2001) was sceptical that professionals would relinquish power by encouraging lay involvement in their field of expertise, having observed how clinicians resisted patient attempts to influence diagnosis and treatment by developing various strategies on patient exclusion (Bloor, 1976). A study of the 'patient-centred medicine' movement in general practice, which sought to empower the patient, found the consultations to be "*artfully contrived, bounded and orchestrated by the practitioner*". It involved particular skills which could be learnt, and thus became "*technical-rational solutions, consciously engineered and maintained by the practitioner*" (Steward *et al* 1995, cited by Bloor, 2001). Such findings augured ill for the aims of the maternity service, as recommended in *Changing Childbirth* (DoH, 1993). The initiative to improve mother's input into their care by providing information, proved equally problematic.

The MIDIRS informed choice leaflets were designed to facilitate consumer involvement in decisions made about their care, by providing research-based knowledge to inform their choices. Evaluation of the initiative indicated cultural inertia and constraints on midwives' time contributed towards the delivery of "*standard packages of information*", as opposed to involvement and a meeting of individualised needs as envisaged. This resulted in "*informed compliance*" rather than informed choice (Kirkham and Stapleton, 2001). Knowledge and power may be closely linked but such links are socially constructed, not automatically established. In the informed choices study organisational and cultural features were seen to mitigate against the effectiveness of the information leaflets.

Not all clients may wish to be actively involved in decisions about their care, preferring the professional to assume responsibility; alternatively they may lack motivation to enter an informed debate over treatment options. In post-modern society, the increase in technology and in expectations, with a concurrent diminution in actual experience can promote a 'professionals know best' attitude, in which people place trust in the expert systems of which they have little understanding (Giddens, 1990).

Caseload midwifery: a new professionalism

The ethos behind the changes in the maternity service and the development of caseload midwifery has been to enable childbearing women to be more actively involved in decisions concerning their care. In the sense that they gained autonomy and developed a specific knowledge base relating to their work, caseload midwives were developing a form of professionalism not experienced within conventional models of practice. This professionalism appeared very different from traditional models, particularly in the relationships the midwives formed with their clients. However, it fitted closely with the ideas raised by Schön (1983) and Benner (1984) of a reflective, expert practitioner whose work defined a new form of professionalism (Williams, 1993; Davies, 1995).

This 'new professionalism' was sited within a radically different knowledge system that emerged from the synthesis of two components: the practitioner's knowledge and the client's knowledge, in much the way posited by Kirkham (1996).

As Schön (1983:296) noted, the practitioner must be "*credentialled, and technically competent*"; a robust and current knowledge of research-based midwifery practice is the minimal requirement. However, 'expertise' is only developed and honed through the application and reflection-in and after-action of such knowledge in Schön's (1983) "*swampy lowlands*" of real life. For the caseload practitioners, these 'swampy lowlands' constituted the reality of mothers' lived experiences as opposed to the institutionally regulated 'real life' in which their hospital-based colleagues worked. The differing situations honed very different forms of expertise.

It is likely that, working with situated 'knowledge' of the mothers' they care for, caseload midwives could more readily achieve the "*connoisseurship*" (Polanyi, 1958) that Benner (1984) considered crucial to the expert clinician. From the Latin *cognoscere* : to know, this finely tuned skill involves the recognition of subtle changes, the significance of which are often only appreciated with knowledge of past history and

current situation. Such "*perceptual recognitional ability*," Benner (1984:5) suggested, is a skill in clinical judgement that remains overlooked in the quest to learn the latest technological procedures. However, the movement away from task-orientation to the more individualised care of caseload practice clearly offers greater potential for its development.

Nevertheless, the new professionalism involves more than the development and application of this knowledge-based expertise. Used appropriately the practitioner must, in anthropological terms, seek the emic perspectives of each client they are working with, and be able to communicate appropriately with them. Once these perspectives are understood, and their views, fears, hopes and wishes acknowledged, care can be appropriately planned together, and provided.

In aiming to maximise the patient's participation and control in their situation, Benner (1984) suggested practitioner should seek to help them use their inner resources, valuing and drawing on the input of the family as additional resources in the formation of therapeutic relationships. Such experiences are the lived reality of midwives and traditional birth attendants in resource-poor countries who, lacking access to technological assistance, support women in giving birth physiologically. They appeared to have little place in the time-constrained environment of the hospital studied, where medicalised childbirth promoted the powers of technology rather than of mothers themselves.

For the practitioner, dependence on the client's participation does not entail an abdication of responsibility but the additional skill involved in identifying and utilising the resources available from the clients themselves. It presents an alternative approach to the use of expert knowledge, based on partnership. One way transmission is replaced by two-way transaction, with the professional building on the existing knowledge and client's experience according to client's perceived needs and professionals' response to these (Williams, 1993).

However, to achieve this situation the practitioner's skills in accessing client knowledge through the formation of appropriate relationships becomes paramount. The suggestion that the relationship the practitioner formed with their client could be more important than their role as expert was suggested by both Walmsley *et al*, (1993:6) and Schön (1983)

Bloor (2001) drew on the work of Richard Korn (1964) to highlight the political perspectives behind the expert-client relationship. In providing a clear comparison between the traditional models and the theoretical model suggested Irwin (1995), Bloor foresaw the potential of the new professionalism that has been identified here in caseload midwifery; see Table 19.

No longer the professional seeking to impose their views, the midwives' role changed from one of controlling to one of supporting and of sharing knowledge, in a way similar to that in education advocated by Freire (1972).

Table 19: Alternative Models of the Social Expert

	Expert as Operator	Expert as prescriber	Expert as co-learner
Action of expert	Does <i>to</i> client what client cannot do	Does <i>for</i> client what client cannot do for himself (sic)	Transactional sharing of learning Does with the client what the client can ultimately do for himself (sic)
Role of client	Total passivity Client as object	Dependency Client as dependent	Active participation Reciprocity, client as colleague
Relational aspects	Dominance-submission	Superordination-subordination	Mutuality
Typical statuses	Surgeon-body	Ruler-subject Parent-child	Siblings Friends

Adapted from Korn 1964:588 by Bloor, 2001

From this perspective, the most important foundation of professionalism is the 'self' of the professional - the ways in which they relate to their client and the interpersonal skills they bring to the transaction. As discussed in the previous chapter, this engagement of 'self' had emerged as a important theme in this study from the caseload midwives. Williams (1993) suggested 'professional' practice now has less to do with the application of esoteric knowledge and more to do with intuition, common sense, techniques for helping and interpersonal skills. Theoretical knowledge loses its centrality in the professional-client relationship, moving from a position of dominance to one of support. The shift also moves from viewing the foundation as scientific rationalism to recognising it as an art (Williams, 1993; Davies, 1995). No longer the

dominant actor, the 'new professional' "*exhibits the humility of interdependence*" (Davies, 1995:150).

This strikes at the heart of traditional professionalism. For professionals who trained many years to acquire a body of expert knowledge, passed examinations to gain qualifications and entry to the profession, it challenges the pre-eminence of their professional knowledge-base, constituting a grave threat. Power is removed from them and handed to the client; the base of their power is now located with their clients rather than their professional body (Williams, 1993).

Characteristics of the new professional practitioner were summed up by Davies as:

- Neither distant nor involved but *engaged*
- Neither autonomous nor passive/dependent but *interdependent*
- Neither self-orientated nor self-effacing but accepting of an *embodied use of self* as part of the therapeutic encounter
- Neither instrumental nor passive but a *creator of an active community* in which a solution can be negotiated
- Neither the master/possessor of knowledge nor the user of experience but a *reflective user of experience and expertise*

(Davies 1995:149-150 author emphasis)

Such characteristics hold clear resonance with caseload midwifery practitioners.

Problem areas for midwives and mothers

This new form of professionalism, as observed in caseload practice, could increase the vulnerability of each participant. For midwives this was particularly noticeable in two situations: adverse outcomes, and rejection of professional advice.

It was inevitable that, during the course of the study, adverse outcomes to some cases would occur. Concern was expressed by both senior obstetricians and midwives that the caseload practitioners might become too emotionally attached to their women and have difficulty continuing to provide care whilst emotionally coping with such 'disasters'. The reported experience of the midwives was the reverse, as discussed in the preceding chapter, supporting Benner's hypothesis that engagement rather than distancing techniques are psychologically healthier for practitioners (Benner 1984:164).

This new professionalism is built on a mutual respect between midwife and mother. Nevertheless, respecting the autonomy of women may present a problem if they are determined to follow course of action that is considered dangerous by the practitioner. Whilst obstetricians can strongly advise a particular course of action and withdraw care

if the mother refuses to accept it, midwives are obliged to provide care whatever the circumstances; this may place them in difficult situations (Harding, 2000). The caseload midwives talked about the advocacy role they played for their mothers, particularly when there was a potential clash with medical opinion. In general the tensions appeared resolvable, although the midwives reported feeling 'piggy in the middle' and being the recipient of medical frustration with some mother's choices.

In some situations, the midwife may understand why a mother adheres to a particular course of action despite clear guidance to the contrary, causing a reassessment of the clinical advice, as Lesley Page illustrated with her case, Jane (Page, 2000:7). Benner (1984) suggested the use of this contextual knowledge above and beyond the scientific is a feature of the expert practitioner. However, difficulties lie when there is lack of support, and judgmental comments are made by colleagues (Kirkham, 1999). Focusing only on the clinical issues of mothers transferred into hospital, professionals condemn the clinical practice of the midwife involved rather than offer the support that may be needed.

Such situations occurred during the course of the study, involving both caseload and community midwives. In all such dilemmas midwives have a duty to liaise with their Supervisor of Midwives; for the caseload practitioners, additional support was available in the form of the Lecturer-Practitioner who attended with the midwife involved in 'difficult situations' (see box 6).

Box 6

Précis of notes:

Discussion over lunch with project Lecturer-Practitioner (L-P) concerning a home delivery which the L-P had got called to when the parents refused advice. They were determined to stay at home despite being informed of the risks that had developed (thick meconium, prolonged labour with minimal progress).

I had met the L-P the following morning when she had been raging angry about being put in the position of having to stay and deliver a baby at home when there were strong indications for hospital transfer. In the end the baby came out screaming, all was well and the parents felt justified in their decisions. The L-P felt they had been very lucky.

The delivery ward consultant joined us at lunch whilst we were discussing some of the related issues. S/he commented on how lucky doctors were in being able to walk away from these situations, whilst midwives legally had to stay.

Note: is such understanding demonstrated in action?

Source: field notes: canteen chat 1996

Although the model of care was set up to enable women to have more control, an inherent danger lay in midwives becoming a powerful group, using the potential for dominating women in the guise of friendly service. Foucault (1980) noted pastoral care as the premier technique of power in late modern society, whilst Benner (1984:216) detailed the potentially negative power of caring, suggesting that “*nursing without caring is powerful and devastating*” with possibly harmful results for the patient, a situation discussed by McCourt *et al* (2000).

Although such demonstrations of negative caring were not observed during the study, the potential cannot be denied. However, early in the project the midwives identified the danger of their clients developing dependency relationships. In strategizing to avoid these, the midwives talked about how they tried to empower women by not doing but guiding, providing information and contacts to support women in their action. Some midwives, particularly those serving the needs of a relatively deprived community, considered they were able to offer their women a positive role model.

Both these problem areas are likely to be minimised if true mutuality and respect become the basis of the practitioner-client relationship. Midwives aligning themselves with traditional professions may not necessarily be to the advantage of mother or practitioner. This study of caseload midwives supports Hugman’s (1991) suggestion that a new ‘democratic’ professionalism, creating partnership and participation, empowers both users and the professional practitioner.

Nevertheless, the resources of the hospital continued to be used for some elements of care in the majority of cases, subjecting both mother and midwife to the controlling environment of the institution. As Foucault noted (Giddens, 1987, 2001) time and space are used as subtle forms of control within organisations. This phenomenon, was seen to have important implications for the caseload midwives so explored in detail in the following chapter.

Chapter 10

TIME: THE ULTIMATE CONTROL

“To practice the science of medicine and analyse and treat the disease the physician distances himself or herself in time from the patient and treats the patient as allochronic, in another time... To practise the art of healing the physician meets the sufferer in his or her own time, as a coeval.” Frankenberg (1992:10-11)

In analysing the adaptations carrying a caseload demanded of the midwives, it was apparent that particular structures that had become separated in ‘modern’ society became fused again. The role and person of the midwife became one, and the professional:client dichotomy became a relationship of mutuality where the expertise of both midwife and mother were valued. Such fusion presented a radical alteration to the way caseload midwives worked.

However, perhaps the most fundamental fusion they experienced related to their use of time. This necessitated a deconstruction of the ‘modern’ way of compartmentalising time, returning to a more ‘traditional’ way of conceiving and using it (Thompson, 1967). Frankenberg (1992) indicated that a different use of time was involved in the practice of the science or the art of ‘curing’. So it was in caseload midwifery. The different way of using their time enabled midwives to meet mothers on a level that acknowledged and facilitated the physiological timing of childbirth. Nevertheless, this change conflicted with the institutional concepts of time and the way time was used by others, generating tensions.

Ideas about time, and the expectations generated by these, influence the way people live and relate to others. An understanding of the way time was used, both within the hospital and when carrying a caseload, will help an appreciation of the very radical differences between the two models of practice. It may also help explain some of the problems experienced, by all groups of staff, particularly in the early days of the project. Those that work in the maternity services are also part of a social world, therefore the implications of such change were wider than the immediate work context. To fully appreciate the impact it is useful to consider the notion of ‘time’ itself and the influences on the ways this has been constructed in ‘western’ industrialised society.

Concepts of time

Time is often thought to be a universal concept, one of the few immutable truths that help provide stability in an increasing complex world. The belief that the existence of the phenomena of 'time', and the way it is both perceived and measured, is constant through out the world is reinforced by constructs such as the International Dateline. Nevertheless, many writers have shown this assumption to be fundamentally incorrect (eg. Thompson, 1967; Whitrow, 1989; Priestley, 1964; Hall, 1959). Diverse notions about time have been identified, and the ways it is constructed, used and interpreted may hold widely differing connotations, both between and within societies (Bloch, 1977; Griffiths, 1999).

Such concepts may be mirrored in a society's language. For the Hopi, they were found to be embedded in their social life and behaviour rather than externalised as a precise category; they had no word for the concept of time in their language (Whorf, 1971). In contrast, the lineal, forward moving notion of time forms an integral part of the English grammar in adverbs and tenses; in the vocabulary, time is accurately divided into seconds, hours, days and it is metaphorically referred to as passing or flowing.

The ways in which time is conceptualised and used can communicate powerful messages. In English it has been externalised, is tangible, a commodity that can be 'bought' and 'sold', 'saved', 'measured', 'wasted', or 'lost'. It is compartmentalised, time is allocated for work, leisure and sleep, and it is used sequentially; it is valued objectively and personally, carefully guarded, and individuals becoming angry if 'their' time is unnecessarily wasted (Hall, 1959, 1976), ideas which, it will be seen, are interwoven within hospital work.

Such notions are not created individually but are "*culturally constructed and culturally represented*", forming collective representations that act as "*a mirror of that society's social reality*" (Durkheim, 1915). An understanding of how time was conceived within the hospital and within caseload practice reflect underlying notions that influence the nature of the services provided. However, as both were situated within the *durée* (Giddens, 1987) of daily life, this must first be addressed.

Time in modernity

The way time is conceived of and used in modern society had been strongly shaped by the influences of religion and technology. Judaeo-Christian beliefs stress the notion of irreversible time; 'switched on' at creation, to be 'turned off' in the future, and the 16th century Protestant work ethic (Weber, 1976), placed a high value on the industrious use of time for spiritual rather than material rewards. Such notions, reinforced by puritanical preachers and social reformers, were subsequently internalised during the Victorian era (Thompson, 1967), promoted with the 'professionalisation' of midwifery (Heagerty, 1997), and remain in the idea of nursing and midwifery sometimes being considered as vocational work.

The industrial revolution had a profound effect, with time's 'inexorable passage' being stressed by mechanisation that altered the rhythm of people's lives, negating natural distinctions of time and reducing the element of personal control over work. The need for synchronisation of labour meant increasing attention was given to time, with people being paid by the hour not the task. Wage labour, and the growth of usury equated time with money and distinguished between private and employer's time. Work became a distinct period of time, and time a currency not to be 'passed' but 'spent' (Thompson, 1967).

Scientific and technological advances have both enabled and demanded increasing accuracy in the monitoring of time. The widespread use of reliable artificial light has overridden the natural patterning of the day, with the positions of clock-hands rather than the sun or moon determining people's activities. From the Egyptian *clepsydra* or early water clocks to the most recent computer developments, monitoring of time has changed from mechanical devices to electronic ones that measure time in nanoseconds (a billionth of a second) (Whitrow, 1989; Hockett, 1973). Such divisions are not 'natural' inevitable phenomena but imposed, constructed in response to change or development in the community; they also change that society. For example: the replacement of the stagecoach by a precision railway necessitated the development of exact timetables; these in turn imposed a particular structure on time and space to co-ordinate the activities of a large number of people (Giddens, 1987). Increasing travel and communication have subsequently necessitated the adoption of a 'uniform' time.

Today, universal education inculcates a time discipline on all. 'Economic' time tends to dominate life, patterning its stages through infancy, learning, earning, retirement, each year (work and holidays) and each day, clearly dividing it into work and personal time – mentally if not physically. Diaries are no longer used to record events but to remind and structure them. The upsurge in the use of filo-faxes and palm computer organisers, and development of various training courses suggests that 'Time Management' has become an economy in itself.

However, "*the citadel of science, technology and positivism (which) ties us to chronological time*" may not be entirely advantageous (Priestly, 1964); machine efficiency does not guarantee maximum efficiency, as regularity fosters apathy and atrophy rather than innovative thought (Mumford, 1963). Also, pressures of tight time discipline are thought to have detrimental effects on mental and physical health.

Such concepts and their consequences are not universal.

'Traditional' time

Pre-industrial societies have been shown to hold very different notions of time, but for all practical purposes 'task-orientated' time is the major framework (Giddens, 1987; Priestley, 1964). With the stress on observed necessities, work is adjusted to the task not the time allocation, and there is minimal demarcation between labour and social activities. In rural societies, specific activities, rather than a clock or calendar, provide demarcating points in time. Routine daily activities divide the day, as in the notion of the Nuer's 'cattle clock' (Evans-Pritchard, 1969), local markets may give their name to the day on which they are held (Goody, 1968), months are named by the predominant activity of that period (Evans-Pritchard, 1969). The concept of seasons is derived as much from social activities as climatic change (Bohannon, 1967) and because a year is related to a cycle of tasks as well as the seasons its length is indeterminate (Smith Bowen, 1964).

Physiological time

Although occurring in societies dominated by specific notions about time, childbirth carries its own time – a physiological time that is imposed on the mother. She commonly ‘slows up’ towards end of pregnancy and may experience changes in sleep patterns. To a greater or lesser extent the expectant mother is being eased into having to use her time in a different way to meet the demands of a new-born that has yet to be socialised into a ‘daily routine’. Labour commences with no reference to what may be socially convenient, and the woman is delivered into motherhood at a pace over which she has minimal control. For millennia, ‘traditional’ birth attendants have supported and accompanied women during this transition, rarely attempting to control or subvert the timing of events that were physiologically inherent. This situation has changed radically in many societies (Davis-Floyd and Sargent, 1997). In an age where time has become inherently scheduled and commodified, it is not surprising to find such control being extended to the arena in which childbirth is now placed.

Use of time

Ideas about time are not homogenous to a society as individuals may favour particular notions. Also, in complex post-industrial society people move between models during their daily life, being forced to acknowledge different attitudes and concepts relating to time simultaneously. For example: the demands for strict time control placed on factory workers and the generally more relaxed demands of family life; a similar difference was noted within the hospital, between delivery unit and ward.

However, the dominant ideas become embedded within the culture of each society both reflecting and influencing the ways in which people think and behave. This may have serious ramifications as concepts about time are relative to societies, dictating how individuals conceive their world and relate to each other. Problems occur when the different sets of ideas about time clash, as when individuals move between countries or, it is argued here, models of midwifery, forming the basis for ‘cross-cultural’ misunderstandings (Carroll, 1990).

The ways in which ideas about time and its usage can be internalised and affect behaviour have been most clearly developed by Hall (1976, 1969, 1959) and are helpful in understanding the different nature of caseload and hospital midwifery practice. The 'task-orientated time' of pre-industrial societies, detailed above, is closely related to Hall's notion of poly-chronic time. This is characterised by several things happening at once and stresses the involvement of people rather than adherence to pre-set schedules (Hall, 1967, 1976). These characteristics may be seen to apply to caseload midwifery.

Modern post-industrial ideas of time are summated in his notion of mono-chronic time, and Hall (1967, 1976) stressed how use of this directly affects attitudes and behaviour. Undertaking activities separately and sequentially implies implicit and explicit scheduling. This involves according priority to people and functions, and so forms a classificatory system ordering life which is so integrated that it appears logical and natural, although it is not inherent in natural rhythms. Prioritisation implies a valuation, and thus the use of time acquires an implicitly recognised code; e.g. a call at 2am has more serious connotations than one at 2pm. Segregation of activities enables total concentration, but 'decontextualises' them and people may become disorientated if they undertake several activities at once. Relationships are intensified but then temporally limited, as in business meetings or hospital appointments, which are private but of fixed duration. Failure to observe the limit implies intrusion on another's schedule, and may be considered ill mannered or egocentric. Such ideas hold strong resonance with the hospital maternity service and help explain negative reactions towards caseload practitioners who worked within a poly-chronic timeframe.

In appreciating the changes faced by the caseload practitioners, an understanding of the way time was conceived and used within the hospital is important. Having come from this system the midwives would have internalised it to some extent. However, they were forced to rethink and develop different ways of using time in caseload practice.

Hospital time

Implications concerning the way time and space are used and controlled within institutions like hospitals have been highlighted by studies such as Frankenberg (1992), Foucault (1973), Goffman (1968) and formed the focus of Zerubavel's *Patterns of time in hospital life* (1979). A predominant feature of such work is an appreciation of the relationship between the control of time and status and power within the institution. For

Frankenberg (1992) time itself and the way it was used and controlled formed a definitive element in the practice of health care and healing. Such a relationship may hold particular implications for a maternity service that has been directed to provide mothers with increased choice and control (NHS.ME.EL(94)9).

Nevertheless, the ways in which time was conceived and used within the maternity service was different from that described by the studies cited. The institutional:real time dichotomy, described by Goffman (1968) and Foucault (1973), and the concept of 'illth' harmonising health and illness, suggested by Frankenberg (1992), proved tangential; birth rather than sickness is the central feature of maternity care. For many women, attendance at the maternity hospital was neither therapeutic nor custodial; the majority of clients were healthy women who could give birth successfully without medical intervention.

How then was time used by the maternity service in this study and in what ways did the new model of care influence the caseload practitioners' ability to practise the art and science of midwifery?

An uneasy alliance

In this study it became apparent that the hospital maternity service necessitated the merger of three, potentially competing, time frames: physiological-time, institutional-time and the personal-time of 'normal' daily life.

- Serving the needs of childbearing women, the *raison d'être* of the service was guided by the physiological time of gestation, of labour, and the demands of the neonate. The service had to be constantly available.
- Serving the needs of many rather than the individual forced a rationalisation and the development of 'institutional' time, as described below.
- The service was provided by, and for, individuals who lived in a world external to the hospital, governed by the complexities of 'normal daily life' and the notions of time described previously. Work or hospital visit remained but one component in these lives.

Within the hospital these time frames formed an uneasy alliance, resulting in a particular patterning to the day and to the organisation of work within it. The potential for conflict between institutional and personal time occurred throughout the hospital,

but those between physiological and institutional time were most apparent on delivery unit.

Although core staff working rotational duties or 'shift work' provided the 24-hour baseline service, institutional time gave the appearance of the patterning of activities of 'normal daily life'. Most categories of staff worked a modified 'office hours' regime, afternoon and evening visiting gave a social element to the day, whilst night time was period of quiet, reduction in noise and lighting being used to encourage 'patients' to rest. Nevertheless, it could be extremely busy at night and a reversal of the natural day:night work:sleep dichotomy was imposed by bright lights being kept on. This subversion of 'normal-daily-life' time by institutional time appeared unremarked by staff, and generally accepted by 'patients'. Time was less tightly controlled over weekends and bank holidays when routine work was avoided and a more relaxed atmosphere prevailed.

The division of time and labour aimed to ensure an appropriate number and skill of staff were available when most required; that it did not succeed was noted by the Audit Commission Report (1997). However, a clearly hierarchical pattern emerged. The association of flexibility and control over one's time being inversely related to status and power within a hospital had been highlighted by Zerubavel (1979) and clearly demonstrated here. Night periods were covered by more junior staff supported by senior or specialist staff working an on call system; the most senior staff, consultants and managers, were rarely seen at night unless called specifically for an emergency situation.

Although serving the needs of 24 hour physiological time, hospital time imposed a strict schedualisation. The day was divided and defined by the clock in the organisation of duty rotas, of clinic schedules and appointments, ward rounds, operation lists and inpatient meal times. These determine where people would be at specific parts of each day and helped ensure all necessary tasks were undertaken. In this manner, time served to regulate and create order out of complexity and, given the numbers of people involved, potentially chaotic situations. Adherence to these 'demands' generated the impression of efficiency and organisation. The requirement to staff a place irrespective of workload belied this impression.

It was also acknowledged by some of the midwives that different perceptions of time dominated different departments within the hospital. Outpatient clinic comprised of two, three-hour, sharp bursts of intense activity each day. These fitted relatively easily into the 'normal-daily-life' time of staff and attendees; acknowledgement of which was emphasised by the importance placed on punctuality, highlighted by the waiting-time audits. The inpatient wards attempted to establish a 'normal-daily-life', 'physiological time' 24 hour rhythm to the day, although this was moderated by ward routines, set meal times, rest times, and the regulated social contact of restricted visiting times. It was also sharply divided by the fast turnover of admissions and discharges; the accompanying administration created intense work pressure for staff even though of a relatively non-urgent nature.

Perceptions of time, and the way it was used proved very different on the delivery unit where the potential for conflict was most apparent. Providing a constant level of cover over the 24 hour period, patterning between night and day was appreciable only by a reduction in the number of staff; the use of bright lighting, particularly when busy, defied natural time, and unrestricted visiting for family members denied social time. However, physiological time cannot be over-ruled with the same ease and inter-professional conflicts of understanding and approach around this emerged as the 'active management' of obstetrics versus the 'waiting' of midwifery.

To some extent the timing of work was initiated and ordered by physiological time, the spontaneous onset of labour, although institutional time was superimposed with work created by elective caesarean sections and inductions of labour. However, it was rare for physiological time to be allowed to proceed without some element of control. Even physiological labours progressing "*efficiently*" and 'normally' were monitored by the clock; constant assessment of contractions in terms of frequency and duration, routine monitoring of the foetal heart, and regular assessments of progress helped tie the labour to chronological time. This was reinforced by a formal, supposedly research-based timeframe imposed on the process of labour (Rosser, 1994), an imposition that was both symbolised and actuated by the board in the delivery unit office (see chapter 4).

In the medical hegemony labour is not a safe time for mother or baby, and judicious intervention is indicated when there is a delay in the process. Although disputes over what constituted 'delay' were recognised, medical guidelines concerning appropriate timeframes were expected to be followed. Perceived delays in progress were quickly

noted and intervention recommended, - a system not just dependent on obstetrician's actions but, as previously noted, internalised and practised by senior midwives. However, conflicts arose between the junior doctors, focusing on time durations and milestones, and midwives, being more inclined to contextualise progress and wait longer. Some of the more experienced midwives talked about strategies used for subverting the time issue of the board, for example by not confirming full dilatation immediately suspected, thus effectively 'allowing' a longer second stage of labour before medical intervention was suggested. Many recognised how the use of the board controlled their work, how *"it sets the clock ticking"*.

Although birth is a normal, physiological process, valid concerns over maternal or foetal wellbeing are not uncommon, and swift action may be required to avoid serious problems. This encouraged an immediate time orientation and it was recognised that the pace of work on the unit may vary very quickly. As one midwife commented *"they work in hours down there"* referring to the wards *"whilst we work in minutes up here!"*

The peaks and troughs of work that are inherent in childbirth and the maternity service generate a clash between the rhythms of nature and those of the institution. At times staff had to remain on duty when there was little work to do; at other times the pressure of work was so relentless and staff so limited they quickly became exhausted and worried about safety levels becoming compromised. A seemingly constant fear of litigation served to increase the stress of these periods.

Partly to avoid such potentially dangerous peaks of work, and thus meet the requirements of the institution rather than the mother, the physiological timing of childbirth had become controlled with the use of dating scans to 'confirm' gestations to avoid potential problems with prematurity or postmaturity. Postmaturity was controlled by artificial induction of labour which, as with elective caesarean sections, was conducted at the 'convenience' of the hospital, not at the ideal gestation date but the closest when the unit has a space in the 'induction/theatre diary'.

The practice of such 'social' and highly controlling obstetric practice has been condemned, even by obstetricians (Savage, 1986; Wagner, 1997). However, the control of time during labour remained a predominate philosophy of the unit, posing a difficulty for the caseload midwives' developing respect for the physiological timing of labour.

Implications for midwives and midwifery

In providing a 24 hour service to a large number of women, the institution developed a momentum of its own. This seemed to have an inherent logic to it, which was then internalised and reinforced by the staff, as demonstrated in the clinic waiting time audits. In clinic time was very tightly scheduled, with the appointment system dictating a strict regulation to the flow of, and time allocated for, attendees. Disruptions to this system quickly caused long delays to develop. 'Waiting times' were a feature of the hospital quality control audit and staff were keen these were kept short. Such strict schedulisation was more likely to enhance the feeling of attending a cattle market, so commonly reported by antenatal mothers, than to improve the sense of quality of care received. However, the hospital midwives considered it important not to 'waste' women's time. Less consideration was shown to the midwives themselves.

In accepting employment, hospital midwives gave complete control over the timing of their work to their employers; inherent in this was a high element of control over their personal lives. Requests for particular duties were acceptable but not invariably granted; a few subverted the control by occasionally reporting sick when a requested day-off had not been granted. Acknowledging the Sapir-Whorf hypothesis (1985:1971) the accepted use of the term 'days off', rather than 'days on' linguistically reflected the domination 'institutional' time had over the midwives' personal time. Personal life was arranged around the needs of the hospital, often to the detriment of the individual - particularly those with young children, as witnessed in tensions generated over cover scheduled for school holidays, Christmas and New Year. The majority of midwives grumbled about personal difficulties incurred but appeared to accept this as "*part of the job*". Institutional time was accepted as the 'norm' for midwifery work.

Not only did the hospital midwives have very little influence over when they actually worked, whilst at work they had minimal control over the place and content of their working time. Meal-breaks were taken when allocated rather than chosen, to suit the workload situation; not infrequently on delivery unit, the relentless demands of crisis situations precluded meal, coffee, and even toilet breaks.

Although Hall (1959,1976) describes notions of 'modern' time as being scheduled and prioritised, within the hospital the midwives were frequently required to undertake many tasks at once, juggling the competing demands of a busy unit, incessant telephone rings, crying babies, concerned relatives and clinical emergencies. Not in ultimate

control of such situations the midwives were forced to be reactive rather than proactive and exhibited the disorientation identified by Hall (1969).

The tightly defined boundaries over the midwives' time generated a short-term focus that forced them into an immediate-task orientation, akin to a Taylor/Fordist division of labour (Godelier, 1988) where activities are broken down to their component parts and undertaken separately. Given the rotational nature of midwives' duties, continuity of carer was extremely limited, so gaining an understanding of the wider context of care, the mother's situation, became almost irrelevant. The philosophy of continuity of care was acknowledged, but so was the reality of conflicting advice given by colleagues.

Given the relatively short duty span in the context of longer care requirements, midwives were unlikely to complete care provision; they had to leave when it was time to go off duty rather than stay and complete the activity, such as assisting with a birth. Thus time, rather than completion of task, becomes the guiding focus of work. Yet this did not sit comfortably with the midwives. Many would 'stay behind', or miss meal breaks when a relief was available at an inappropriate time for the mother. Such practises were not encouraged; one midwife reported how a sister "*refused to allow*" her to stay on duty for the delivery of a mother she had been looking after. The reality of getting off duty at 10pm to return for 7.30am next day, the potential consequences of travelling through an inner city very late at night, particularly if reliant on public transport, and the certain knowledge that the extra time worked would not be remunerated or allowed for later, mitigated against such enthusiasm.

Hospital midwives were contracted to work 37.5 hours per week with a specific holiday entitlement. Payment for extra hours worked was not available except in exceptional circumstances; midwives were expected to 'take back' time when the unit was quiet by going off-duty early. However, the reality of understaffing and increasing workload meant they were rarely able to do this. Several senior midwives were 'owed' many hours, which they recognised they would never be compensated for. True commodotisation of their time had failed, ironically resulting in the institution 'stealing' an employee's time because they had focused on completing the activity for which they were employed rather than the time 'allowed'. This situation did not apply to community midwives who completed time-sheets to claim for work undertaken 'out-of-hours'.

The use of time within the maternity hospital took on symbolic valuation, and most importantly, developed a momentum that appeared unalterable. 'Time' became predominant, internalised and accepted as the normal, sensible way of 'doing things'. This held important implications for the way midwifery care was delivered and for the midwives as individuals. Such notions were challenged by caseload midwifery practice, as detailed below; a summary of the differences is presented as Table 20.

Table 20: A comparison of orientations towards, and use of, time for Midwives

Hospital Midwives	Caseload Midwives
Contracted for 37 1/2 hr work per week	Contracted for care of 40 women per year
Commoditised time – extra payment for 'unsociable hours'	Set extra allowance irrespective of time of day worked
Extra hours worked not paid	Not applicable
Clear divide between work & personal life	Work 'embedded' in personal life
Request particular days off	Negotiate free time with partner & group
Minimal flexibility to change duty	High level of flexibility
Work according to fixed duty-rota	Work when needed by women
Work period intensely busy or quiet. Unable to take advantage of quiet periods. No balance reported	'Long hauls' and quiet periods when minimal work. Can use to personal advantage. Reported to balance over time.
Work 'time' directed & controlled by hierarchy	Self-directed except where 'controlled' by labour and emergencies
Rota orientation – leave work when 'due off' – obstacles to staying	Activity orientation – finish work when activity completed
Current work has present orientation (task in hand)	Current work has future orientation (investment in future care provision)
Midwives' 'time' has a future orientation - immediate future work-time known	Midwives' 'time' has present orientation – immediate future work-time uncertain
Time is routinised, controlled, scheduled, de-personalised	Time is purposeful, flexible, uncertain, personalised

Time and caseload midwifery

Caseload practice required a radically different orientation towards time. The new style of practice challenged the notions previously developed within the hospital service, forcing midwives to redefine their concepts about time and its use. In 'giving back' to the midwives their control over their time, the maternity service implicitly acknowledged the control it exercised over those remaining in the conventional service, a feature that was apparently not overtly recognised.

The different orientation towards the use of the caseload midwives' time was structurally defined within their contract. They were employed to undertake specified activities rather than provide a set number of midwifery-care hours. Operationalisation of this requirement was at the discretion of the individual midwife and fixed additional payment, irrespective of actual 'unsocial' hours worked, facilitated their flexibility.

This strategy effectively de-commoditised the midwives' time. It also removed the pressure to complete an activity within a specific time, for example: before going 'off-duty'. By altering the focus of work from time to activity, midwives worked when and as they determined or were required. Thus they were able to use their time more effectively, no longer having to 'waste' it by going 'on-duty' when it was quiet and no work was actually required.

Without close managerial direction, the midwives now 'owned' their time and were able to deploy it as they considered appropriate, spending as long or as short a time as they considered appropriate to achieve the activity in hand. One midwife describing how she managed this situation noted: *"I tend to do less visits over a longer time"* (i.e. of longer duration). This presented them with enormous flexibility. Inevitably some variation in the way they structured their time developed. Some chose to start work early, others later in the day; some scheduled their routine work into a few long days whilst others planned for a more even spread.

Arranging cover at night and weekends was equally flexible. Some midwives preferred to remain available for their women, recognising the limited chance of being called, whilst others opted for alternating the night-cover with their midwifery partner, preferring the higher chance of being called one night with the certainty of not being disturbed the other. Such flexibility enabled each midwife to negotiate with their partner a pattern of working that best suited their lifestyle. Moreover, as their lives and commitments changed, such patterns were relatively easy to alter and adapt.

"You actually have to plan better when you are working shifts...I find I plan on a weekly basis... whereas before, when I was on the wards, you have to plan three weeks in advance because that's the way the rotas are done"

(i.pm04)

Unexpected events could be accommodated in a way they found impossible with fixed hospital rotas (e.g. by sharing and back-up within the group or by re-scheduling more routine activities). The midwives did not have total control over their time as they had to be available to respond to the needs of their women. Nevertheless, once they had developed their personal time management skills and learnt to advise, or "educate" their women appropriately they reported the interruptions at night were usually confined to labour and emergencies and proved to be minimal.

"At night? It's not very often. I would say on average a month I would get three. You can't put (a number on it) ... Or you may be contacted three times in one night!"

(i.pm06)

Such reporting was verified in a study of their work diaries (McCourt, 1998).

Knowing the women who contacted them enabled the midwives to respond appropriately, not necessarily having to visit but give advice or make an appointment. This contrasted with their colleagues in the conventional services where calls from 'unknown' women had to be treated with care; with no prior knowledge of particular situations, most calls necessitated the woman being asked to come into hospital or visited at home by the community midwives.

These two features, knowing the women and infrequent night calls, were symbiotic; in relating to the person of their caseload midwife rather than the role, women were reported as not wanting to disturb her unless it was urgent. This appears to be one of the most misunderstood features of caseload practice. In considering this model of care both midwives and doctors related to the term 'on call' as in their own experience where they were invariably disturbed. Alternative models, where they were 'available' yet rarely called, appeared incomprehensible.

Nevertheless, the onset of labour and other emergencies would prove disruptive to the midwives at times. Scheduled work required reorganisation and, if called at the end of a day's work, physical stamina for the "long haul" as the midwives termed it, was needed. However, they said these busy period were balanced by the quiet ones when they could relax at home or with friends.

Working with women's time

As their time was not tightly defined or structured, and largely within their control, the caseload midwives were able to work within women's individual time constraints. They reported undertaking early morning or, occasionally, evening visits to suit the convenience of the couple they were seeing; this was a situation the Community Midwives reported being unable to undertake as they could not be paid for such 'overtime' visits. Two community midwives undertook such work but they were the exception rather than the rule, and not paid for such 'dedication' (Kirkham, 1999).

Caseload midwives also appeared more willing to work within women's physiological time frame, perhaps because of their greater knowledge and understanding of personal situations, and the greater flexibility they experienced personally. With minimal previous experience of home births, the midwives reported finding that deliveries at home had a very different quality. They became more aware of the physiological rhythms of labour, which, away from the constraints of hospital-dominated time were found to be very different from that they had considered 'normal' (Flint, 1986). The midwives considered they learnt this by having to advise women during the early stages of labour and then caring for them through the active phase, rather than providing an eight-hour period of care isolated from the wider context of labour.

With experience the midwives undertook an increasing amount of care during the first stage of labour at home, moving into hospital for birth when appropriate. Towards the end of the study they talked about making the decision for place of delivery during labour itself, when it was considered to be most appropriate, although this was not then accepted procedure.

The caseload midwives tried to subvert the hospital-time imposed on labour by a strategic use of 'the board' in delivery unit; as previously noted, this refusal to comply with accepted procedure generated tension on the unit. Also, with a greater understanding of individual situations, they became more flexible in applying the unit's guidelines and protocols concerning labour. In describing a difficult delivery involving a long second stage, one caseload midwife explained that, because she was aware that the mother was unsure of the parentage of her child and was fearful of her baby's colour at delivery, she considered the delay was due to the mother psychologically holding back. In this situation the midwife considered that, while indications of the baby's

wellbeing were satisfactory, support and understanding were more appropriate than speeding up the labour with hormonal stimulation.

In such situations, providing they could justify their careplan to the obstetrician's satisfaction, if questioned, the midwives' decisions were usually respected. Where they were not, usually by a less confident registrar who did not know the caseload midwife and imposed intervention, the midwives reported later proactively following up such unsatisfactory management with the delivery unit consultant. In becoming confident to question medical behaviour in this way, the midwives had to be very sure of their own management. This also reflected a growing confidence with their body of midwifery knowledge.

Implications for caseload midwives

Such flexibility held distinct advantages for midwifery practice and mothers, as described. Nevertheless, personal adaptation by the midwife was not necessarily easy or successful. As highlighted in chapter 6, it took many months to settle into working this way and the most fundamental adaptation, although not overtly recognised, was likely to be to the different notions and uses of time.

Their lives were no longer clearly compartmentalised into the scheduled trichotomy of work:social/domestic:sleep of Hall's monochronic time (1969) but work became embedded in the general passage of their lives in much the way Bourdieu (1963) described for the Algerian peasant or Bohannan (1967) the Nigerian Tiv. This lack of compartmentalisation of time may also be considered a feature of post-modernity, with the movement to more flexible patterns of working, in both time and space, indicated by the development of 'flexihours' and home-offices. It is certainly a feature of the lives of a level of those in more autonomous positions, such as senior corporate managers and senior professionals (Giddens, 1987).

This way of using time had a direct impact on the way the midwives viewed their lives; it also held a certain ambiguity. Long-term planning was important for negotiating holiday time, and a balance to the caseload; it also incorporated the essence of 'investment' in their work discussed previously. However short-term planning was less assured, forcing a more 'present' orientation. Nevertheless, although they would know due dates for delivery and might have a sense of impending labours, they never knew when they would be called. Even when quiet, their busier colleagues might require

support. The midwives recognised it balanced out, that periods of intense activity would be followed by quiet spells. However, their appreciation of the quiet times was probably more retrospective than immediate, the exact duration of the quiet period only being defined once it had passed.

On a day-to-day basis the development of a forward orientation was limited as anything planned during 'available' periods could be disrupted by unexpected labours or emergencies. The ability to plan in certainty and enjoy the anticipation of particular social activities was determined by the support provided by their partners or group, and defined by whatever strategies for cover they had negotiated.

The midwives mobile phones became both the symbol and reality of this embedded work, freeing them to go wherever they wanted, within reason or social dictates for the use of mobile phones, when officially 'available' but also interrupting such activities with the demands of their caseload. This extended into all aspects of their lives, with coitus interruptus laughingly being described by some as a new form of contraception.

Once they had become used to it, for some midwives the phone was reported as giving them freedom and 'helping them make the job work for them'

"I take the phone where ever I go and it doesn't really affect me."

(i.pm05)

Another equated it to her "right arm".

To others it gave confidence; they could contact women about whom they were concerned, but more importantly, the women could contact them, a situation which helped some midwives to relax. Nevertheless, some midwives appeared unable to completely relax, and reported great joy in handing in their phone when leaving:

"I couldn't wait to give back the phone once I knew I was leaving. I felt so tied. Tied by the phone you know. If you go out of the city for the weekend you can only go so far (when 'available'). You have to be reached by the phone. That takes its toll."

(i.PM07.2)

Adaptation to this 'embedded' more traditional use of time was dependent on both personal characteristics and personal situation. It clearly suited those with a flexible and relaxed attitude towards work and life in general, proving more problematic to those who enjoyed living very structured lives. This different approach to 'work time' also made different physical demands on the midwives.

Acknowledging the times when they would be called to a labour after a working all day, these “*long hauls*” as they termed them necessitated a type of physical endurance that differed from the extremely intense, yet relatively short (8-9 hours) term endurance demanded by busy shift duties. One of the midwives who decided this style of practice was not for her commented that she had found out she was a twelve-hour person, after that she could not cope without sleep. Other midwives preferred the less stressful though longer days to their experiences in hospital. In comparing her experience with both systems, one midwife commented that she would rather be “*knackered than demented!*”, a comment illustrative of the difference between the physical tiredness experienced in caseload practice and the mental and physical exhaustion experienced in the hospital service.

Considering the problem times, a midwife highlighted the difference between short-term not coping and long-term not coping, suggesting there was plenty of the former in caseload practice but implying the latter belonged to the hospital, a comment holding resonance of Sandall’s (1999) conclusions concerning burnout amongst midwives.

“It’s not a continuous thing that goes on for months or weeks on end – it’s only a few days. But it’s difficult and there is really not anyone you can go and say... If we do complain it’s ultimately thrown back in your face (by managers) as “You don’t manage time effectively””

(i.pm06)

The requirement to be able to manage their time effectively was appreciated by the implementation team but was not identified by the selected prospective caseload practitioners when training needs were being established. However, as one later noted, until they had the hooks to hang it on, such training would have been pointless. Once they had some experience of the implications of carrying a caseload, time management training was welcomed.

Time Clashes

Many of the difficulties the midwives experienced as caseload practitioners related to clashes experienced at the interface between their ‘traditional’ / ‘post-modern’ concepts and uses of time and others’ ‘institutional’ or ‘modern’ notions. These occurred in their domestic situation, with some of their clients, and when working in the hospital.

Domestic

'Clashes' that developed in the domestic domain were highly individual, and depended on particular circumstances. Undertaking domestic chores was considered easier by some, although others reported their social partners undertook more of the domestic duties such as cooking. Being called when socialising with friends was difficult for some, whilst others said they experienced minimal problems in negotiating such situations; most midwives commented on not being able to drink alcohol when 'available', but reported adapting to this.

Individuals who valued highly an extremely active social life reported no problems providing their work-partner agreed to a determined and reciprocal cover arrangement, such as alternate nights and weekends. Tensions emerged when such arrangements proved difficult, as when one partner wanted to cover for her personal caseload most of the time, offering rarer and specific cover for her partner, whilst the other preferred a more routine arrangement of alternate nights and weekends. Such clashes were best resolved by changing to work with more like-minded partners.

Midwives with stable and established live-in relationships appeared to experience less domestic tension than those with new or changing relationships. Those whose partners who worked set 'office' hours reported seeing more of them as they were more likely to be at home in the evening.

"my husband works 9-5 hours but I find it works to my advantage, I have more free time and am usually at home for supper rather than out 2-3 times a week"
(fg.nm.pm31'97)

The midwives contrasted this with hospital work where, with evening and night shifts, couples met as "*ships that pass in the night*", particularly if the partner also worked shift duties. The greatest problems occurred when couples lived apart, particularly if separated by any distance. Tensions arose when visits together were interrupted by calls to work.

During the data collection period only a few midwives had young children to care for. However, from the limited data available it became clear that any problems resulting from the midwives flexible work patterns clashing with more structured childcare arrangements were an individual rather than inevitable feature of the model. Two midwives reported finding childcare when working with a caseload considerably easier than with the shift pattern of work, but they acknowledged they benefited from flexible

and supportive domestic arrangements such as the close proximity of supportive 'grandparents'. Others experienced greater difficulty, and reported feeling guilty when relying on friends to assist.

This situation exemplifies one of the difficulties of using time in a more traditional way within a society that is structured and dominated by scheduled industrial time. In traditional societies childcare is commonly conceived of as the responsibility of the wider family, not just the mother. Where specialised childcare arrangements have to be adopted the uncertain nature of caseload practice can result in high fees or high levels of stress. One midwife reported leaving caseload practice when her childcare arrangements proved so difficult that she realised she was providing better care for her clients than her family; the situation proved untenable. However, she considered she could not, and did not, return to hospital clinical practice.

Client

Although the reports were few, it became apparent that some clients experienced difficulty with the flexibility that was an integral part of the midwives' use of time. Living within a structured, scheduled time frame, their highly organised lives were disrupted when planned visits had to be cancelled at short notice (for example, for the midwife to attend another mother's labour). One husband wished to lodge a formal complaint to the Trust, explaining how angry he had become when, having cleared time from his city occupation in order to meet the midwife, this visit was postponed at the last minute. He clearly considered his time had been 'stolen' by the midwife's inefficiency. In industrialised countries, punctuality is indicative of efficiency, although elsewhere aspects relating to respect, status or power are more heavily stressed (Hall, 1959:1976). Such clashes, unless recognised and tactfully handled, irritated clients who then interpreted the midwife's behaviour as disorganised or unreliable.

Mothers who did not have a telephone presented a particular problem. Serving a relatively deprived community in some patches with an increasing refugee population, some mothers lacked telephone access. Changing their appointments proved difficult, although usually a male relative would have a mobile phone; communication was made that way but was not considered reliable.

Hospital

More serious difficulties developed when the midwives interfaced with the hospital service, where institutional time predominated. Problems were generated both in the way activities were undertaken and the negative stereotyping which developed from misunderstandings, a situation well recognised in cross-cultural misunderstanding relating to time (Hall, 1956, 1969, 1979; Carroll, 1990; Griffith, 1999).

The interface in outpatient clinic was reported as a constant problem by both groups of staff. Clinic was managed on a tight schedule and waiting time audits were commonplace. Therefore the hospital midwives reacted sharply when caseload midwives did not appear as arranged, leaving their clients waiting for what was deemed 'unacceptable' periods (although the evaluation indicated 'caseload mothers' waited for shorter times overall). They also complained of the caseload midwives spending "*too long*" with women and so "*blocking*" rooms. As there were 20 caseload midwives, and several might have clinic appointments at similar times, undoubtedly they caused serious disruption to the smooth running of clinic, a situation which various strategies were adopted to help minimise.

In the more relaxed atmosphere of the inpatient wards, the hospital midwives still complained that the caseload midwives were inefficient and disorganised; they appeared at irregular times of the day and could not be relied upon to attend when planned. Hospital midwives initially had difficulty defining the idea that caseload midwives would provide 'all care'; many chose to interpret it literally and frequently both mothers and caseload midwives reported 'essential' care being delayed until the caseload midwife visited. In such situations the caseload midwives were reported as being lazy, poor timekeepers, and totally disorganised, descriptions not infrequently applied to the same hospital midwives by the caseload practitioners. Both students and junior midwives noted how some hospital midwives phoned the caseload midwife for non-emergency queries at any time of day or even night. The perception acted on was that as hospital midwives covered the hospital 24hour a day so did the caseload midwives, therefore it was appropriate to contact them at 3am for a minor query.

On delivery unit, where time took on a shorter, more concentrated dimension, the relaxed attitude and flexibility of the caseload midwives proved particularly irritating if the unit was busy as described in Box.17:

Box 17

8.30am

The unit is frenetically busy, staffing is difficult and there are a number of emergencies. Access to the telephone is constantly required.

One of the two phones is being used by a caseload practitioner to reschedule her day's work, having brought in a lady in labour. She is unaware of the intense irritation she is generating by her relaxed and humorous, although totally work-orientated, conversation. Her use of the phone lasted about ten minutes.

Nothing is said but strong 'looks' are exchanged between medical and midwifery staff.

Note: The caseload midwife's character was visually assassinated!

A clear example of a 'time-clash'.

Source: DU. observation study no.10 1997

A second area of tension arose between the shorter periods of duty and longer duration of caring for a woman throughout labour, where caseload midwives received little help from hospital staff. Particularly in the early days, the hospital midwives considered it inappropriate to offer help. However, they did not fully appreciate how long a particular caseload midwife had been on the unit, nor their previous workload prior to attending the labour. The attitude of non-support may have been fuelled by the caseload midwives initial reluctance to update the board on the unit, recognising they did not wish to "*set the clock ticking*" and be dominated by medical time and interference unless requested. As a result, the sisters-in-charge of the unit were then identified by the obstetricians as not knowing what was happening. As a response some of the sisters appeared to marginalise the caseload practitioners. This situation diminished over time but unsupportive behaviour was still noted from a few hospital midwives at the end of the data collection period:

"some people are loath to do even little things for you, whilst others can be so nice, and even when it is heaving will ask 'are you alright?'"

(fg.om.'97)

Time and radical change

Frankenberg (1992:16) suggested that "*Revolutionary changes in health services, ... require that time itself is turned upside down*", commenting how, in '*Das Capital*' Marx exhorted workers to take charge of their own time. He also noted how a more egalitarian form of health care, defining carers and cared for as equal participants in the

healing process would neither need nor be able to treat the time of others as within its control.

Practising with a caseload involved a radical change for midwives, not least in the way time was conceived and controlled; this held fundamental implications for the midwives' work and lifestyle. The more reciprocal relationships established with mothers included a mutual respect for each other's time and, with a less controlled patterning of their own time, midwives gained a greater appreciation of the physiological timing of labour.

Such adaptations are not necessarily compatible with an individual's personal characteristics, preferences or domestic situation, and for this reason caseload practice must not be considered as the only way to practice midwifery. Diversity in models of practice is essential to enable midwives to move between forms of practice that suit their changing personal situations. Nevertheless, this study indicated that many midwives might find the style of individual caseload practice more acceptable than the confines of hospital practice and the institutional domination of their time.

Frankenberg (1992) remained pessimistic as to the viability of the change he had outlined, considering such relinquishment of power to be idealistic. Somewhat appositely he used the metaphor of childbirth when presenting this idea, suggesting:

Historical changes, like women in labour, still need midwives, even if for both they can most usefully be chosen from among their friends."

(Frankenberg, 1992:18)

The nature of caseload midwifery practice appeared to support his views on revolution and egalitarian health care. The fact that it had been successfully implemented, as indicated in this study although only as a small scheme, undermines his pessimism but concurs with his valuation of 'friends', albeit it 'professional-friends.

Chapter 11

SUSTAINABILITY OF CASELOAD MIDWIFERY

Although caseload practice clearly increased these midwives' sense of job satisfaction, to the degree that they expressed dismay at the prospect of returning to more conventional forms of practice, it is necessary to consider whether the model is sustainable in the longer term. In particular it is important to identify issues that are specific to this local situation and those more applicable to the model in general.

Consideration will first be given to the midwives' view of the service and the reasons why some left. Then, following a reflection on the concerns presented in studies of other 'continuity' schemes, those features that appeared to support and sustain this model of practice will be summarised.

Caseload midwives' views of the model

In assessing whether caseload practice was a sustainable model or not, the views of all midwives who had worked in it were sought again at the end of the data collection period. A questionnaire (appendix 2) was distributed to past and current midwives in which they were invited to identify the strengths and weaknesses of the service in general, and three positive and three negative aspects they had experienced working in it. Of the thirty five questionnaires sent out, thirty were returned. Their responses are summarised in Tables 21 and 22 respectively.

The midwives' comments on the service indicate it held positive benefits to both mothers and midwives. The weaknesses identified related to both local issues, and others common to the wider context of midwifery work; however, ongoing practical and psychological support, or lack of this, was identified as a key feature of this model

Table 21: Perceived strengths and weaknesses of the current service

<u>Positive Features</u>	
For women:	Achieved individualised, quality care for women and their families Provided continuity of care and carer
For midwives:	Gave fulfilment and job satisfaction Developed all skills Provided good peer support Gave valuable experience for students
For service:	Achieved goals of Changing Childbirth Co-ordinated multidisciplinary care meeting client needs and preventing duplication Motivated midwives
<u>Negative Features</u>	
Lack of support: limited resources	
Poor senior management support	
Relations (tensions) with hospital staff	
Poor cover for sick-leave etc	
Service was geographically limited and seen as elitist (expansion desired)	
Lack of child care facilities for midwives	
Lack of promotion opportunities	
Practical issues (various cited)	
Service delivery over 2 hospital sites	

1997 Questionnaire response nos. 30/35

Table 22: Summary of midwives' views about working in the 1-1 service:
(positive and negative points identified)

<u>Positive Points</u>	<u>Negative Points</u>
<p><u>Current midwives</u> nos. 19 + 3 maternity leave</p> <ul style="list-style-type: none"> Relationship with women & their families Autonomy of practice – working independently, organising own work Professional development – practising in all areas; obtaining feedback, opportunity to reflect on practice Continuity – both within pregnancy and between pregnancies Group/peer Support & shared philosophy Flexibility of working hours Job Satisfaction Variety – clinically & cultural mix of clientele Working in community 'Being a person' <p><u>Leavers</u> nos.8</p> <ul style="list-style-type: none"> Standard and type of care provision: <ul style="list-style-type: none"> able to offer high standard holistic care, professional fulfilment Relationship with colleagues Relationship with women Job satisfaction 	<ul style="list-style-type: none"> Attitudes of hospital staff: midwifery, medical & management On call Uncertainty about future of project Demanding women Long hours Conditions of service (eg. pay & holiday, smaller caseload; problems with lease cars & phone bills) Inadequate staff cover / shortages Colleague partnership problems Working over 2 hospital sites <ul style="list-style-type: none"> Poor Support – poor backup when sickness, very busy, delays in filling vacancies, Interpersonal conflicts, Hospital interface (attitudes of staff) Intrusion of work into personal space & time

1997 Questionnaire response nos. 30/35

Their views about working this way echo the analysis of interview data concerning the meaning of caseload practice for midwives. They particularly valued the professional development and relationships they were able to form with the women and their colleagues; both contributed towards increased job satisfaction. However, their views on difficulties experienced reflected both the demands of the job and management issues related to the local situation, and complaints of midwives more generally concerning pay and conditions of work.

‘Turnover’ Rate

The attrition rate of midwives in this context - inner city teaching hospitals in an area of high mobility and housing costs - were generally high. In line with national staffing problems, the ‘turnover’ rate and unfilled vacancies in this trust as a whole increased during this period, reaching very high levels during 1997. Routinely collected data showed no clear differences in midwifery turnover between the pilot and conventional services. The turnover was higher for the project in 1995, the final year of the ‘pilot’, when seven midwives left during a four-month period of uncertainty about renewal of their contracts, whilst in subsequent years it was lower than for all midwives in this Trust.

From the project, fifteen midwives left during the research period November 1993 - August 1997, 12 of the original and three of the midwives appointed subsequently.

Reasons for leaving

It is possible to distinguish differences between two separate groups of midwives working in the project. The first group had to act as change agents, carving out a midwifery service from within a predominantly medical dominated, medical model of childbirth, whilst the second group needed to refine the service delivery. Quite different demands were made on each group. This in turn may have had an affect on attrition. In this study the analysis of the reasons midwives left focused on data from the original midwives as the subsequent group of leavers were only three in number and had left for particular reasons, as indicated:

- * one left after three months, having been awarded a fully funded place, previously applied for, for Health Visitor training; this person was not included in any data collection because of their short duration in the project.

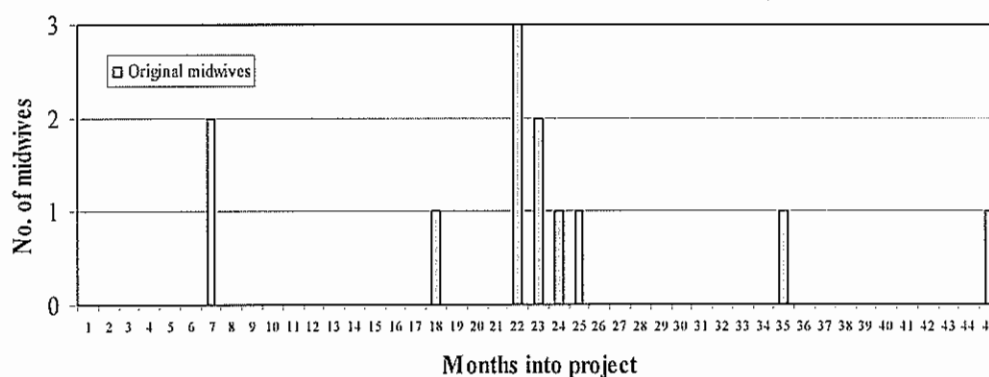
- * one person employed on a temporary contract covering maternity leave, left for a senior position elsewhere but returned, on a lower grade, when a permanent caseload contract became available.
- * one left due to circumstances rather than choice with the break-up of a job-share arrangement. This person transferred back into the hospital service.

Data from the original midwives offers an understanding about the demands made on them during the early stages, highlighting some of the weaknesses and lessons to be learnt from this implementation.

Of the original midwives who left, one remained with the Trust working in a non-clinical position; four remained in clinical midwifery in other Trusts, three in higher graded positions; two undertook full-time studies in midwifery, and five left to travel overseas.

The motivation to leave may be a result of several factors that interact with each other rather than one particular issue, so it is important to recognise the complexity of the situation. Analysis of when midwives left, as presented in Table 23, highlighted that two midwives left after seven months, during the transition period which involved a very 'steep learning curve' and before they had learned to 'make the job work for them'. They clearly felt unsuited to caseload practice. Also, seven midwives left during the period August '95 to December '95. This was a time of considerable uncertainty and change in the project and its management, with the midwives considering they were receiving little assurance from management concerning the future of what was initially a two year project. Motivation to move was clearly enhanced by a sense of poor job security and feeling undervalued.

Table 23: Number of 'original' midwives leaving by month of project



An analysis of both exit interviews and questionnaire responses identified several themes which could be grouped into four key areas: personal circumstances, personal characteristics, pilot scheme characteristics, organisational issues.

Personal circumstances

Work was undertaken within the context of particular domestic arrangements and a social life. As discussed in the chapter concerning time, in caseload midwifery these elements were symbiotic rather than exclusive. Thus many of the midwives left when their personal circumstances changed. The movement of a partner (3) or development of a family proved particular catalysts although such changes did not inevitably precipitate a move. The midwives discussed how a forthcoming change had caused them to re-evaluate their situation; resignation was not automatic but a carefully considered preferred option. One midwife, whose partner's work moved overseas, considered staying and periodically visiting him but rejected this as not being financially viable; another clearly wanted to continue with caseload practice but was torn when her partner moved away. Two years later she noted in her questionnaire:

“If I had remained single I would probably still be there now as I really enjoyed it”.

(qr.pm22)

Initially, the data suggested that caseload midwifery was incompatible with a young family, as the three midwives with young children all left (2 original, 1 subsequent midwife). However, the analysis indicated that the situation was dependent on personal circumstance and support mechanisms. One midwife with a young child, who was job sharing, resigned when she found the uncertainty of being called out and the requirement for constant negotiation and re-negotiation childcare arrangements exhausting and detrimental to her family life. In the two other situations, the midwives with young children considered caseload practice to be compatible with family life; one who had children when working in the hospital service reported finding it easier in caseload practice. Both had excellent childcare arrangements and support and valued the flexibility caseload practice offered them. Nevertheless, they were both ‘forced’ to resign when their situations changed; one moved out of the area, away from supportive relatives, and the other's job-share arrangement collapsed.

Supportive and flexible childcare arrangements proved to be essential features for mothers carrying a caseload. Helpful factors included the presence of a wider, supportive family

network and partner's work commitments that were flexible and family friendly. Compounding factors included a domestic partnership isolated from close family support or a strong network of friends, or a partner whose work commitments were rigid in structure (e.g. duty rota) or particularly demanding.

Personal characteristics

Caseload midwifery practice was not suited to everyone because it demanded a radically different attitude towards work, and in particular the use of time and a blurring of the work:leisure dichotomy. Several midwives who delayed joining the project reported their initial concerns about the perceived requirement to be 'constantly available' for mothers. Several appreciated the opportunity to "test out" the practice by undertaking maternity leave cover; all these midwives subsequently applied for and were given permanent positions within the service. However, with no previous experience to inform the twenty original midwives, and no opportunity to 'test it out', invariably some individuals were less able to adjust to the different lifestyle that the unpredictability of the work dictated.

One midwife noted how she did not possess the physical stamina occasionally demanded by the "long hauls" when called out after a day's work and that:

I've discovered that I'm a twelve-hour person and after twelve constant hours of working I rapidly go downhill and become very irritable, short-tempered and feel stretched to the limit.

(i.pm01.2)

With experience, the midwives reported the 'long hauls' became less frequent, and in developing strategies of coping they became more manageable. Such strategies included: keeping in touch with women at home during early labour but not staying with them if not needed, appropriately using students to stay with women for periods in early labour whilst they complete other work or got some rest, and calling colleagues when getting too tired. Nevertheless, the midwife quoted found herself unable to relax when 'available' and clearly preferred a more defined working day.

Another midwife recognised she had made a mistake in her approach to her work but felt unable to change her practice. Locked into a particular, self-imposed, way of practising (independently and aiming for 100% continuity of care) which she later considered detrimental to herself and her clients, she was leaving in order to change. Her move was not a rejection of the style of service but an acknowledgement of the importance of defining the boundaries correctly and not encouraging people to depend on her

inappropriately. A third midwife, leaving after two years, stated that she had enjoyed the work and considered she had done a good job but that the style of practice was not suited to her personal, highly social, lifestyle.

Features of a pilot scheme

It has been suggested that the project proved successful because it attracted highly motivated midwives who were unique in some way. The data suggested any difference was attitudinal, attracting those who sought a challenge. Personal characteristics that are demanded by and honed during a difficult implementation are not so important during the subsequent development of the service. It is possible that individuals who rose to and enjoyed the original challenge felt less 'stretched', and even became bored, as the service was established. They left to seek further challenges elsewhere; one commented that caseload practice was *"not as stimulating to me as it was"* (i.pm07.2), another left to

"progress further...to learn more about research....to consolidate my experience in an academic way. ... I'll be upset to leave, but I'm moving on".

(i.pm05.2)

A third, although considering that *"working this way is very, very rewarding. This is midwifery"*, was leaving to seek further challenges elsewhere:

"I want a major change in my life at the moment. I'm leaving my boyfriend, I'm leaving my job, I'm leaving my family, I'm leaving my friends. And it's going to bring me challenge."

(i.pm06.2)

Finding fulfilment at work does not necessarily stop individuals leaving to seek fulfilment in other areas of their lives.

Organisational issues

It was clear that the implementation period carried stresses that the midwives found particularly tiring. The following comments, taken from one exit interview, illustrates some of the pressures involved in their working environment during the project's earlier days, a period they called *"the initial 'proving' period"*:

" (It was) *organised chaos*"
"*coping with medical and midwifery colleagues' anxieties as well as your own*"
"*everyday there is a battle about something*"
"*there was always something you had to be confrontational about*"

(i.pm01)

The impression of being constantly involved in a battle was reflected in discussions with other caseload midwives, as was a strong sense of the amount of energy they had put into the project. The energies demanded by any implementation are in excess of 'normal' working conditions. With this project, the requirement to meet the demands of the service and the expectations of the implementation team and midwifery profession, in the knowledge you were being carefully scrutinised by an extensive evaluation, intensified the situation. The midwives were also testing different ways of working, rejecting those that proved problematic and trying new ideas that might work for them; compounded with colleague movement and partnership changes the drain on their energy levels was high.

The initial management of the project had combined good support with a facilitative approach. However, once the project was incorporated within the mainstream service the midwives felt they had lost managers to whom they could turn for support. Continuing indecision about the future of the practice added to their general sense of uncertainty and of being undervalued.

"We are still 20, we haven't even achieved the 24 originally aimed at: I don't know about rolling it out, we cannot even cover all of (the areas designated). We have never had a clear answer - that is the reason a lot of girls left. We have lost a lot of brilliant girls".

(fg.om.'97)

The remaining midwives felt strongly that some of their colleagues might not have left had the service been more clearly supported by senior management within the Trust. The support desired was identified as recognition, both verbal and financial, for a job well done, as well as assistance with problems the midwives were unable to resolve; for example: ensuring they were not left covering two caseloads by providing cover arrangement. The importance of appropriate support has been identified as a major theme of the research, having been raised by all the midwives at different times and in different contexts. In responding to the "*Why did you go*" section in the questionnaire, two years after leaving one midwife wrote:

"Lack of support and teamwork from partner. Lack of support from management re above. Working on my own. When management (was) made aware, no support (was) given and (I was) basically told to get on with it."

(qr.pm07)

In discussing her reasons for leaving, one midwife highlighted support as the fundamental requirement for this style of practice. When asked if this style of working was feasible, she responded:

"YES (adamantly) Yes it is, if you have got the backup. If there is properly organised back up to cover sick leave etc".

(i.m05.2)

These factors are not intrinsic to caseload midwifery practice, but if they are present and are not recognised and adequately addressed they may prove to be fundamental in motivating midwives to resign.

Caseload midwifery and alternative models

It is helpful to consider the sustainability of caseload midwifery in relation to the issues raised by the evaluations and commentaries of a number of midwifery schemes introduced since the 1980s.

As noted in the background chapter, a wide variety of Team Midwifery schemes were implemented prior to the Winterton and Cumberlege reports, aiming to enhance the midwife's role and provide a less fragmented service for mothers (Wraight *et al*, 1993). These varied in size, they were located in hospital or community (very few covered both), and they aimed for very different degrees of continuity over the antenatal, intrapartum and postnatal periods. Although most were not evaluated, problems with these schemes became apparent. Midwives reported achieving higher levels of job satisfaction and valued a wider use of all their skills. However the need for increased flexibility was problematic and the accommodation of part-time midwives awkward (Stock and Wraight 1993). The fundamental difficulty was in creating an acceptable balance between providing continuity for women and midwives having time off.

The debate concerning definitions of 'continuity', as continuity of 'carer', 'caring' or 'care' (Lee 1997) stemmed from this period. Uncertainty over the central issue questioned whether it was more important for women to see the same person or to avoid conflicting care and advice being given. Several writers suggested that the latter could

be achieved though the adoption of standard protocols for working and similar attitudes and philosophies agreed through the formation of mission statements (King's Fund, 1993; Lee, 1997).

A variety of organisational changes were introduced to address the issue. Individualised care plans, 'patient allocation', DOMINO schemes, nursing/midwifery process model, and team midwifery were all identified in a study of maternity services' responses to improving continuity of care in Scotland (Murphy-Black, 1992; 1993). Team midwifery was considered the only change that successfully achieved both continuity of carer and care (Murphy Black 1993). Similar changes were underway in England.

The difficulty in balancing the needs of women with those of midwives remained the fundamental problem of changes introduced in response to the government directive (NHSME EL(94)9). The findings of the evaluations of the newer schemes mirrored those identified by Stock and Wraight (1993) and raised a number of questions concerning the viability of continuity schemes. In their review of the evidence, Green *et al* (1998) identified three key questions:

- How important is continuity for women?
- What does 'knowing' really mean and what effect does this have on outcomes of care?
- What are the costs to midwives of providing continuity of care?

From the preceding chapters it is clear that this study is able to inform aspects of these questions and offer an understanding from the perspective of caseload midwifery practice as experienced in one particular situation. It is not the intention to suggest that a definitive answer can be provided, clearly the subject is far more complex than one study can address, nor to claim that caseload practice is superior to other models. Each midwifery service is unique, designed for specific populations and situations. The aim is to use the findings of this study to address the questions raised by the other studies, in the context of the sustainability of this and other such models of midwifery practice.

In approaching these issues, two fundamental differences between this study of caseload practice and the other studies need to be acknowledged. One concerns the nature of pilot studies, the other the philosophy of midwifery.

Pilot study or honed service

One of the difficulties in assessing the findings from the evaluation of pilot schemes is their short duration. The findings of this study suggest that the short time span applicable to most evaluations provided a questionable basis from which to draw sound conclusions concerning viability.

Stock and Wraight (1993) indicated that any new scheme should have a long planning period, approximately 18 months, which involved wide consultation with all parties. This recommendation has not been heeded in most schemes (Green *et al*, 1998).

However, as Allen *et al* (1997) succinctly summarised,

“Demonstration projects set up with limited funding for limited time, little lead-in time, staff who had not worked together before, new methods of management and practice, high expectations and little experience of managing change can expect to experience multiple problems.”

(1997:227)

Despite this recognition, the indications are that some pilot projects have been closed down as a result of such problems being highlighted (Hart *et al*, 1999).

This longer-term study indicated that many of the so-called ‘problems’ of continuity schemes are likely to become resolved over time. However, such resolution is not accommodated in pilot schemes nor acknowledged in short-term evaluations, none of which appeared to last longer than 18 months. One might also argue resolution is not automatic and will depend on the way change is handled and how organisations do or do not learn from experience. From this study it was clear that:

- a) The initial ‘teething problems’ associated with the changes were resolved, as the strange became familiar and accommodations were made. However, this did not happen automatically and required an appropriate framework within which changes could be negotiated.
- b) The adaptations demanded of the midwives in changing their style of practice took time; the ‘transition period’ for the ‘original’ midwives’ was estimated as lasting ten months.
- c) ‘Problems’ found in other pilot schemes were identified in caseload practice and they required specific acknowledgement and strategies developed to avoid or overcome them. For example:

- Allen *et al* (1997) noted difficulties with group relationships became so bad that one group called in an outside counsellor to help them resolve their differences. In this caseload practice study the role played by the group, in terms of support and practice development, was highlighted as crucial. Poor inter-group relationships proved disruptive and destructive. Good relationships could not be assumed but had to be worked at; occasionally the input from a supportive and empathetic manager was required. Such 'group relationship' skills had not been honed in the conventional service where strategies of avoidance rather than resolution were more commonly exercised. These skills developed with experience.
- Both Green *et al* (1998) and Allen *et al* (1997) questioned the cost to the midwives personal lives, highlighting problems with the formation of dependency relationships with their women and the potential danger of working when fatigued. These were also identified as concerns by the caseload practitioners, although proved to be potential rather than actual problems. However, they highlighted the importance of each midwife clearly defining their boundaries, and accepting responsibility for when not to work, as much as when to work. 'Appropriate' guidelines, and managerial and peer support that draws on such experience, were found important in helping midwives develop appropriate boundaries and approaches.
- Allen *et al* (1997) suggested that "*potential resource implications are very high if midwives provide 24 hours on-call cover for their women*" (p.234). They noted this had been resolved in one situation, the scheme analysed here, by a negotiated salary enhancement that was considered an important modification. The findings presented here support that statement. Issues relating to use of time and control of time were fundamental to caseload practice (see chapter 10). The removal of the constraints of an economic valuation placed on time, where budget limitations for overtime and unsocial hours payments impose particular working hours, facilitated midwives' flexibility over when they provided care.

Allen *et al* (1997) also raised the issue that high levels of consumer satisfaction may be associated with groups of dedicated and committed midwives rather than a feature of a particular model of care. They should not be assumed to indicate the model as the ingredient of success. Although an important point, it was a reflection on newly implemented schemes rather than established services. This raises three issues:

- 1) Although such schemes may attract highly motivated personnel, their enthusiasm is likely to be mitigated by the stresses of implementation and learning the job. The findings of this study suggest that it took at least ten months for the midwives to settle into the new style of work and possibly considerably longer to become truly proficient at working this way.
- 2) The initial midwives acted as 'change agents', and were likely to move on. A study of the subsequent practitioners offers a sounder basis from which to draw conclusions. This point is verified by a comparison of the first and second evaluations undertaken on this caseload project which indicate positive changes with continuity and, in some areas, improvements increasing over time (Page *et al*, 2001; Beake *et al*, 2001).
- 3) An assumption should not be drawn that the qualities of the midwife bear no relation to the quality of her working conditions and expectations. Organisational features clearly enhance or constrain personal characteristics. This study found that dedicated and committed midwives were contemplating leaving midwifery rather than staying in the conventional service, which they considered unacceptable. The model should be considered successful if such midwives are retained within the profession because of it.

Minimal change and unhelpful evaluations

The second important consideration relates to the philosophical underpinnings of the pilot services and their evaluations. Although the schemes were introduced with the intention of improving the service for both mothers and midwives, many failed to embrace the fundamental challenge laid down by Winterton and Cumberlege, that of replacing the medical model of childbirth with one that is woman-centred. In Davis-Floyd's terms, this required replacing the technocratic model with a humanistic, or even holistic model (1992; 1999).

Some of the main influences on the control of childbirth, which resulted in the dominance of the medical model in England, were outlined in chapter 3. Nevertheless, such a model is not exclusive, as acknowledged in care developed in other countries (DeVries *et al*, 2001), particularly Holland (Jordan, 1993) and New Zealand (Guilland and Pairman, 1994). Nor is it necessarily advantageous, as increasing intervention rates indicate (Thoman and Paranjothy, 2001). Also, an increasing body of research highlights the value of non-technological interventions, such as support during labour (Hodnett, 1997; MIDIRS, 1995). However, despite support for alternative models, achieving a radical change, as was accomplished in this caseload project, is not easy; as *Changing Childbirth* acknowledged, “*there will, naturally, be some who oppose it*” (DoH, 1993:71).

Nevertheless, schemes introduced with relatively minor changes, such as hospital-based teams designed to minimise colleague disruption, merely ‘tinker at the edge’ of the situation. Sandall’s (1997) work and other reports suggested they generated increased levels of stress for midwives, minimal change for mothers, and disruption to all without major benefit to any (Fenwick and Morgan, 1998).

Moreover, some of the evaluations were designed to test the new model for outcomes considered appropriate to the original model, not the change intended. In this they supported a medical model of care, precisely that which was questioned by the recommended change in practice. As such, they are of limited benefit, and perhaps even destructive to the aims of more fundamental change. An example of this is Allen *et al* “*questioning the wisdom of offering home visits to women who were not ill in the light of GP problems with home visiting*” (1997:238). This comment reflected a particular way of conceiving childbirth, as a medical model. When childbirth is considered as the ‘normal’ physiological process involved in creating a family, the home becomes more relevant. In terms of gaining an understanding of the mother’s situation, in order to deliver appropriate advice and care, it may be considered essential - a situation in line with the recent government emphasis on midwives having more role in public health and health promotion (Mason, 1996; DoH, 1999). As Perkins and Unell warned, “*outside researchers*” may be blind to such fundamental issues (1997:45).

The medical model of birth is clearly reflected in questions that seek to audit continuity of care, particularly intrapartum care. In focusing on identifying whether a mother was ‘*delivered by*’ a known midwife, the following issues are denied:

- a) during uneventful labour and delivery the midwife's role is supportive rather than active. It is likely, but not necessary, that the most effective support can be more readily achieved by someone known to the mother.
- b) that in a normal delivery the mother delivers her baby, assisted by the midwife.
- c) the care provided by a 'known' midwife throughout labour, in the event of an assisted delivery by an obstetrician (forceps/ caesarean section)

In denying these issues, the reason for attempting to achieve continuity is also denied; continuity of carer is a means to women-centred care, not an 'end' in itself (McCourt and Page 1996). Also, not only is the philosophical basis questionable but even in its own terms, focusing on the person who undertook the 'delivery' rather than the care provider during labour (point c), will distort the results (see also Perkins and Undell 1997).

Due to the philosophical difference underpinning the model of caseload practice, this analysis can offer different perspectives on some of the issues, identified by the shorter evaluations, which remain central to current debates.

The value of continuity

The issue of continuity remains the central debate of discussions concerning the new schemes and, as such, reflects the 'tinkering' at the edges of the fundamental change in service delivery recommended by Winterton (HoC, 1992) and Cumberlege (DoH, 1993).

As previously noted, the aim of reducing fragmentation of care had been addressed either by providing continuity of care, usually by teams of midwives sharing similar philosophies and protocols for working, or continuity of carer, where care provision is limited to one or two practitioners. However, as Lee (1997) detailed, both concepts have been defined in differing ways, and implemented through a variety of different organisational structures, which leads to confusion for comparative assessments.

Nevertheless, it is apparent that continuity on occasions has become a feature in itself rather than part of a mechanism for enhancing the quality of care. Ironically, at times adherence to the desired feature has been shown to reduce continuity overall. Research

on midwifery teams indicated that in some cases, particularly with larger teams, the ante- and post- natal continuity of care sometimes achieved by conventional community midwifery was compromised by attempts to provide a familiar face at delivery (DoH, 1993, p.15; Wraight *et al* 1993; Todd *et al* 1998; Green *et al* 1998; Hart *et al* 1999).

Several evaluations have suggested that trying to provide continuity increased the job stress for the midwives involved (Allen *et al*, 1997). Sandall's (1997) doctoral study found that team arrangements did increase midwives' stress; however lower levels were found in true caseload models and the lowest levels in traditional community midwifery. Nevertheless, the perception and expectation of high levels of stress on midwives working with a caseload have led people to question whether continuity is important enough to women to warrant the demands placed upon midwives (Lee, 1997; Green *et al*, 1998; Hart, 1999). Placing an alternative emphasis on the other two 'c's of the Winterton report (HoC 1992) and *Changing Childbirth* (DoH, 1993), the issues of *choice*, and *control*, has been recommended (Warwick, 1997).

Evaluations that attempted to assess the importance mothers placed on being delivered by a 'known' carer suggested it did not rate very highly (Hart *et al*, 1999; Waldenström, 1998; Fleissig and Kroll, 1996; Lee, 1994). However, the methods used, particularly the use of ranking questions, raise questions about the validity of such conclusions. Splitting elements of care in the assuming they are unconnected denies the interplay between them; for example that choice may be enhanced by other issues (Kirkham and Stapleton, 2001). Common sense suggests that 'safe' 'friendly' care with 'clear explanations' and 'choice' are fundamental features of a service, not desirable qualities to be ranked alongside 'previously met midwife' (Hart *et al*, 1999). Also, statements of satisfaction with a service are influenced by expectation and experience; they cannot be interpreted as everything being 'well' and improvements not desirable (Perkin and Unell, 1997). Other studies have identified women highly valued being cared for in labour by someone who had provided care during pregnancy (McCourt and Page 1996; Perkin and Unell, 1997; Beake *et al*, 2001).

The methodological difficulties of assessing the importance mothers place on continuity are well recognised (Porter and MacIntyre, 1984; Garcia *et al* 1996, Green *et al*, 1998; Walsh, 1999), but the questions remain in the commentaries and evaluations. In particular, in their review of continuity schemes, Green *et al* raise the central question "what does it mean to 'know' your midwife?" (1998: 63:136)

The 'known' midwife : the 'known' mother

This issue received particular attention in two of the key indicators of success recommended in *Changing Childbirth* (1993:70):

- 1 Every woman should know one midwife who ensures continuity of her midwifery care – the named midwife (no.2).
- 2 At least 75% of women should know the person who cares for them during their delivery (no.5).

An understanding of the situation is confused by the variety of definitions of 'known midwife' found in the literature and lack of homogeneity in even one situation. For example: in Perkins and Unell's (1997) study definitions used by professionals were either "a woman having met her midwife before" or "close personal relationship between mother and midwife"; the mothers themselves valued "meeting the midwives a few times". Also, as Green *et al* (1998) noted, many evaluations did not define what they meant by 'continuity' or how this related to a 'known midwife'.

The government dictate for a named nurse and midwife (DoH, 1994) was "*that women must be told the name of midwife who will be responsible for their care*", the ultimate test of success being that "*women can say the name of their midwife*" (The Patient's Charter Group, 1991). Lee (1997) contrasted these rather empty statements with Flint's (1995) suggestion of "*being and becoming the named midwife*" involving a personal and cosy "*relationship of trust*" between midwife and mother. What may be the key words in the quotes, 'responsibility' and 'trust', have been overlooked. The significance of "responsibility" (DoH, 1994), the issue of 'ownership' as accepting responsibility for care, and the concept of 'knowing' as a developing process of "being and becoming" over time, are rarely considered in association with 'knowing' in the literature.

Perhaps it is more helpful to consider the alternative side to the question. Rather than asking what does it mean to 'know' your midwife, identification of the implications for the midwife of 'knowing' a mother may prove more fruitful for service development considerations. From the findings of this study some of the benefits of the situation become transparent.

‘Knowing’ for the caseload midwives meant having clinical, social and psychological knowledge about the mother. Such knowledge would deepen over time, continuing into subsequent ‘maternity care episodes’. This held important implications for care delivery:

- Repetition in history taking was avoided. Information was built on and developed, as opposed to being repeated, with each visit.
- When called by telephone midwives could ‘put a face to the name’ and were able to assess the nature of the call in the light of their understanding about the individual and her circumstances. Care then provided was both ‘personal’ and appropriate.
- Knowledge about each individual enabled appropriate care delivery to be more easily achieved. For example: caring for a distressed mother during labour; where the actual source of distress may be understood (e.g. maternal fears about the baby’s parentage, or past sexual abuse), as opposed to assumed to be physiological and related to purely physical pain.
- It involved issues of security. When attending a mother at home at night, the midwives would know where they were going and who in the mother’s family would be available to meet or accompany them in potentially insecure situations.
- The relationship developed over time, with important facts only being highlighted as trust deepened. For example, previous sexual abuse was only disclosed very late into the pregnancy. With some studies suggesting a 1:3 rate for abuse and domestic violence (Aldcroft, 2001; Gutteridge, 2001) the implications for practice, and mothers, are profound.
- As the midwives’ ‘knowing’ extended into mother’s subsequent pregnancies, they were able to base advice given on their shared past experiences.

‘Knowing’ for the midwife also involved a reciprocal relationship. This had important implications for the midwives themselves and the sustainability of their work:

- Although the extent of personal disclosure was in the control of each midwife and varied according to individual and situation, the midwife was related to and respected as a person, not merely a role.

- The significance of such reciprocity for the positive psychological well-being of both mother and midwife has been discussed in chapter eight.
- On a more practical level, mothers respected a midwife's personal time and tended not to disturb them during 'unsocial hours' unless in an emergency. The midwives suggested some mothers even delayed going into labour until 'their' midwife was available, either the next morning, after a weekend off or even a holiday. Although the issue is highly speculative, the midwives perceived this and considered the mothers were responding to them. Such ability to delay labour until safe or 'convenient' is supported in studies of primates (Trevathan, 1997).

This study offers a more profound understanding of the nature of 'knowing' in clinical practice. As can be seen, these characteristics are not necessarily related to the depth of personal involvement of mother or midwife in the relationship, as the factors identified would apply to even the more 'professional' relationships. 'Knowing' becomes a part of the *process* of caseload care; it is not a feature *sui generis*.

Continuity and caseload practice

The 'cost' to midwives of providing the high levels of continuity of care achieved with caseload practice has frequently been questioned (e.g. Allen *et al*, 1997; Green *et al*, 1998), the perception being that it is unsustainable. However, it was clear that providing continuity of care was fundamental to the job satisfaction levels these caseload midwives achieved and that they considered it made their work easier in many ways. Although difficult at times and requiring considerable flexibility, contrary to perceived wisdom, providing continuity of care could be seen as a source of a reduction rather than generation of stress. However, it is likely that this was achieved because of the particular features of this model; it would not necessarily apply in the same way to everyone – since some midwives' personal circumstances might make flexibility particularly stressful.

The implementation of caseload practice in this study involved a fundamental change in midwifery practice. The features of autonomy, responsibility, continuity, and flexibility, in relating to a defined caseload, were found to be symbiotic and iterative, developing over time and providing strength and sustainability as well as safety.

Implementation of 'parts' of the package, as has been undertaken elsewhere, alters the 'balance' and is likely to generate stress and prove less sustainable.

For example: Pankhurst's (1997) study of the Brighton scheme indicated that midwives remained attached to GP surgeries, resulting in variable and unpredictable caseloads. They were also used as a reserve workforce for the hospital, providing cover for both the labour ward and clinic as well as their own caseload. The necessity of having to keep working after a night up with a delivery because of the requirement to run a routine clinic, or difficulties finding someone to 'cover', were features of many schemes and reported by the community midwives in this service studied. Such constraints severely affect the midwife's flexibility and prevent her 'making the job work for her'.

This study of caseload practice strongly supports the findings of Sandall (1997) who, in examining three different models of care, identified occupational autonomy, social support, and developing meaningful relationships with women as key issues necessary to sustain continuity of carer schemes. Similar themes emerged from this study. When considered with other emergent themes, an attempt has been made to unpack the issues further by focusing on the implications of control and use of time, and the significance of reciprocity in 'meaningful' relationships. Support, both professional and domestic, remained an underlying theme throughout the study. The importance of Sandall's key themes has been reiterated by Hunter (1999) who drew on her oral history work with pre NHS community midwives to consider their sources of job satisfaction and stress in relation to Sandall's findings. Despite carrying caseloads which would be unacceptable today, and working without the backup of partner or group practice, these midwives reported gaining immense satisfaction from their autonomy of practice, their sense of position in the community and the relationships they formed. Hunter concludes the themes of autonomy and meaningful relationships with clients were as relevant to sustaining pre-NHS midwifery practice as they are today. In my personal work with Traditional Birth Attendants it was clear that such issues were also highly relevant to them. The 'embedded' relationships developed by assisting the deliveries of generations within small communities, and the respect accorded to them for their work, were tangibly different to the relationships formed by the government health workers in the same communities. Such evidence is highly suggestive of these issues being fundamental to the work of a 'mid wif'.

In the wider context of midwifery work, such findings are supported by Mackin and Sinclair's (1998) study of midwives' experience of stress on the labour ward. They

identified generally high levels of stress, which were associated with lack of control, lack of autonomy, problems in inter-professional communication and too little time to perform their work to their personal satisfaction. They also saw the emotional demands of caring for labouring women as a source of stress (Mackin and Sinclair, 1998), rather than the source of satisfaction identified by caseload midwives. Conversely, Hunter's (1999) study of student midwives found that they did not find the emotional labour of caring for women giving birth or labour problems as stressful. For the students, the sources of stress they experienced related to the behaviour, negative relationships and ways of working of the qualified midwives they had to work with (Hunter, 1999). The "*role deprivation*" (Benner, 1984) experienced by labour ward midwives, in their inability to undertake their work as personally desired and considered acceptable, encourages the adoption of an alternative role, that of the obstetric nurse identified by Mason (2001).

Mackin and Sinclair's (1998) study reflected many of the issues observed and personally experienced whilst undertaking clinical duties during this study of caseload practice. When reflecting on the sustainability of caseload practice, the enduring question always arose as: why did midwives stay in the hospital service? If any of the three models observed appeared unsustainable the hospital model appeared most insecure in terms of midwives' distress and high attrition rate. When asked informally why, despite their obviously high levels of stress and low morale, the midwives remained, the response invariable related to financial commitments; they just could not afford to leave.

Caseload midwifery: a sustainable model

In considering the sustainability of caseload midwifery, it is important to recognise that the service in which it is delivered and the individuals who deliver it are not 'static'. The model studied here was evolving and changed in response to alterations in the service management and composition of the group of midwives. Such flexibility is likely to prove a major contribution to the sustainability of the model. Identification of the features that promoted this is helpful.

A supportive and facilitative rather than controlling management ethos, structure and philosophy of practice were seen to be central to the model, encouraging a sense of ownership amongst the midwives. Organisational features that promoted autonomy, responsibility and continuity of care also contributed toward this. An emphasis on

‘learning’ rather than ‘having to know’; reflection on practice aided by regular peer review and audit of care, and the facility to organise seminars as the need arose helped maintain the vibrancy of the midwives’ practice. The provision of appropriate administrative, practice and management support was necessary to enable the midwives to function appropriately.

Constraints such as working imposed duty rotas rather than negotiation with partner and group, having to attend regular clinics rather than arrange individual visits, and being used as a ‘reserve work force’ for hospital, would clearly place additional, and unnecessary, strains on the midwives, as would inflexible and ‘heavy handed’ management. Such constraints would prevent the midwives in developing appropriate ways of working that made the job sustainable for them individually

A positive environment was also important. New schemes and inexperienced midwives are vulnerable and require extra support and encouragement. The backbiting and open criticisms highlighted by Leap (1997) and Kirkham (1999), or the condemnation of ‘unsafe practice’ made by colleagues (medical or midwifery) before fully appreciating a situation, as reported and witnessed during this study, does little to promote professional confidence and development.

Clearly this style of working appeals to some midwives whilst others will not desire or be suited to caseload practice. Personal characteristics, particularly adaptability, flexibility, and good communication skills appeared important and were further developed through experience in this style of practice. Midwives deeply encultured in a technocratic, medical model of care, are more likely to find this mode of working difficult and stressful. However experienced, the necessary adjustments involved in a change in territory, use of time, and clinical adaptations can be problematic. Unable to pass responsibility or rely on colleagues to make decisions, in effect to ‘hide’ as in conventional services, individuals are forced to confront their abilities as a midwife. Compelling reluctant practitioners into this style of work is unlikely to help them through the adjustment period and would be ill advised – for the sake of the mothers and midwife. Students who experienced caseload practice during their training are likely to fit more readily into this way of work.

Caseload practice may be viewed as ‘freeing’ midwives’ time and enabling them to combine their social and professional lives to the benefit of both. Conversely it may be

viewed as burdensome, constraining a personal life. The balance between the two positions is very fine and may be 'tipped' from one to other, for example, by an inappropriate workload, such as too large a caseload or lack of support to cover illness or maternity leave. Also particular circumstances, such as family commitments that alter over time may cause midwives to review their personal situations and leave caseload practice, albeit for a limited period.

Caseload midwives do not work in isolation; they were clearly part of a team, of several teams:

- their caseload colleagues, who offer immediate support and advice by phone or personal contact,
- their hospital-based colleagues, both medical and midwifery, who provide expert advice and additional care where required,
- their community colleagues, the mother's GP, Health Visitor, Social Services Supporters and a wide range of professional and community services,
- the mother and her family, who may provide unexpected sources of support (Benner 1984) and without whom the midwife would be redundant.

Each of these teams contribute towards supporting, and are supported by, caseload practice, providing the strength and stability to help maintain a sustainable service. Nevertheless, the abilities of individual midwives to adapt and determine ways of working that suited their personal circumstances were fundamental. Clearly defining their boundaries, both professional and personal, to themselves, their colleagues, mothers and their families on their caseload, and their domestic partners was essential for personal sustainability in carrying a caseload.

Once these features were present, midwives were seen to gain enormously from this style of working, both professionally and personally. The organisational features of autonomy and continuity supported the midwives development towards becoming expert practitioners (Benner, 1984) and they reported experiencing high levels of job satisfaction. Their positive involvement in their work and issues of reciprocity suggest caseload midwifery may be a highly sustainable model of service delivery, of benefit to both mother and midwife.

Chapter 12

CONCLUSIONS AND IMPLICATIONS

This final chapter synthesises and integrates the key themes of the study and places them within the framework that has been developed throughout the thesis. The implications of these findings for practice and service development are outlined. The methodology is critiqued by reference to the strengths and challenges of the study, and areas for further research delineated.

It will be argued that in caseload practice midwives were ‘given back’ features of their work that had been subsumed within the institutionalisation and increasing medicalisation of childbirth. This study indicated that carrying a caseload presented a ‘hidden’ and, as portrayed in the bottom layer of the iceberg, fundamental challenge to all practitioners, offering the potential for re-defining the nature and experience of midwifery and the development of a new form of midwifery professionalism. The study also illustrated the way in which organisational features can influence the practice and meaning of midwifery. In particular, the provision of continuity of carer, if properly supported, forms the fundamental basis for the success and stability of caseload practice. However, caseload midwifery is not about independence. It was seen to be about the creation of teams - involving mother, midwife and obstetrician, and the relationships involved in this, and about power and reciprocity, and support.

This thesis does not argue that the model studied is the only way to practice midwifery; it does contend that caseload practice presents a viable option for midwives.

Although setting the context for the development of caseload midwifery, the summary presented in the following section provides an understanding of why the study indicated in many ways that midwifery has come ‘full circle’. However, this thesis argues this is not a complete circle but a spiral in which the strengths of traditional models are drawn on and combined with positive features of modernity which include the appropriate use of technology.

From mid wif to midwife to mid wif - the changing role of the birth attendant

During the past century technological developments have both enabled and supported an increasing 'globalisation' of many aspects of society. Ideas and practices concerning childbirth have not remained unaffected by this movement. The dominance of western notions about pregnancy and birth have been promoted through education and example, and further disseminated by the use of the internet. English is the international language of science and an English-style medicalised model of childbirth promoted as the "*authoritative knowledge*" (Jordan, 1993) and solution to high mortality rates. (de Brouwere *et al*, 1998; Kamal, 1998; see also Wagner, 1997)

This transfer of knowledge also involves the exportation of ideas that have been found problematic for mothers and their birth attendant and, given the iatrogenic effect of routine intervention, potentially detrimental to childbearing. In England these arose as a consequence of changes in British society that resulted in a movement of childbirth from the private to public domain. The movement was partly due to developments in technology perceived to assist birth, the control of access to these by the medical profession, and the development of a welfare state that facilitated that access. The relationship between mother and midwife was weakened by attempts to professionalise the occupation of midwifery at the beginning of the century, and undermined by alterations in the 'economic exchange' of the midwife's labour, particularly with the implementation of the welfare state and NHS. This situation was compounded by the increasing institutionalisation of childbearing. Childbirth became removed from its social situation to form one of the 'dis-embedded' (Giddens, 1990) features of modern life.

The institutionalisation of birth facilitated a medicalisation of the childbirth process with a consequential 'objectification' of both mother and midwife. The person of the mother became lost in a focus on the medical 'process' of childbirth, and the person of the birth attendant, the midwife, subsumed within a Taylor-Fordist (Doray, 1988) task-oriented role that helped support the 'production line' producing 'live healthy babies'. The previous autonomy of midwives, and much of their role, was lost as obstetricians assumed a sense of 'ultimate responsibility' for care provision.

The validity of the objections raised by mothers and midwives who sought a balanced alternative to the interventionist approach of obstetrics were acknowledged by the Select Committee (HoC, 1992) and subsequent Expert Maternity Group (DoH, 1993). Their recommendations to address the problems presented a radical change from the medical hegemony by placing mothers at the centre rather than periphery of care and acknowledging their right to exercise choice and control in the decisions made concerning that care. The benefits for mothers to establish a relationship with their care-provider were recognised and provision of this recommended. Hospitalisation of all birth on the grounds of safety was not supported, and the role of the midwife as appropriate care-provider for normal childbirth re-affirmed. These recommendations received government support and became adopted as policy for the maternity services.

This promised to alter the fundamental philosophy of childbearing, and required a radical change to the organisation of maternity services. Women were no longer to be dominated by a scientific rationalism that ignored their individuality and experiences, and midwives were 'given back' their role as birth attendants supporting the needs of mothers rather than those of an institution. Many of the older midwives commented on the system of care going 'full circle'. However, whilst the new ideology was well supported, the practicalities of implementing such a radical change generated concern, particularly over midwives' willingness and abilities to undertake a different style of practice. The state had 'given back' to midwives their responsibility with normal birth and the facility to work in a more 'traditional' manner, but the consequences of this change for the individuals delivering such care and the wider maternity service were unknown.

The key recommendations of the Expert Maternity Group were operationalised within the model of caseload midwifery that formed the focus of this study. Twenty midwives, trained and experienced in a highly medicalised maternity service were given responsibility to provide midwifery care to 40 mothers per year irrespective of associated risk factors. In facilitating mothers' choice for care to be provided in community or hospital, the midwives were effectively 'taken out' of the institution and placed 'with' the mothers, to work as, when and where required by their caseload. Liaison with other professionals was fundamental to their work, but care of normal pregnancy and birth, wherever provided, was the responsibility of the midwife, not an obstetrician.

The consequences of this change were carefully evaluated, this thesis being drawn from the arm of the study that focused on the implications for professionals delivering care. Insights gained from this analysis offer important perspectives on midwifery, particularly the interplay between organisational features and practice.

The significance of mid wifery

One of the intentions of the model was to facilitate the re-development of the role of midwife, 'giving back' to midwives features of their work that had been subsumed within the institutionalisation and increasing medicalisation of childbirth. Caseload practice fulfils the ideology of midwives as autonomous practitioners delivering all aspects of midwifery care to individual mothers; an ideology promoted in training and supported by legislation but generally experienced as otherwise (Robinson, 1989; Hunt and Symonds, 1995; Davies, 1996; Kirkham, 1999) and observed as such in this study site. Such conflict proves a major source of frustration to many midwives. Several of the caseload practitioners reported seriously considering leaving midwifery had the project not been implemented, indicating that such problems may contribute towards an attrition of highly motivated midwives who are not prepared to tolerate the frustrations experienced within conventional services.

The model was found to have been highly successful with the midwives delighted that they were able to practice what they termed "*real midwifery*". Such response begets questions concerning the 'midwifery' they had been practising within the hospital and community services. Analysis of the adaptations experienced by midwives entering caseload practice highlights many of the differences between the models, and illustrates the way in which organisational features can influence the practice and meaning of midwifery.

In caseload practice responsibility, autonomy and continuity were identified as the central organisational influences, supported by the partnership and group structure. The significance of these are perceived as follows.

In being given responsibility for all midwifery care of a defined number of mothers, rather than responsibility for a defined area of work, be it a department within the hospital or geographical location in the community, caseload midwives are encouraged

to focus on the individual as a whole rather than specific tasks. All aspects of midwifery are practised on a regular basis and in a variety of situations, according to the needs of individual mothers. Without the constant presence of obstetricians or senior midwives to refer, or defer, to, accepting responsibility for care 'forces' midwives to make decisions and motivates them to obtain the skills and knowledge required by providing an immediate meaning and purpose to their learning.

The "*steep learning curve*" identified as part of the transition into caseload practice reflects the reality that, although initially trained to undertake such work, the experiences of hospital-based midwifery, in particular, promote an ossification of these abilities. Periodic rotation through different departments encourages a transient expertise in specific areas, which diminishes on moving elsewhere. Expertise in the 'whole' is never achievable and, as Schön (1983) suggested, encourages a 'parochial' narrowness of vision.

Moreover, caseload practice requires midwives to 'situate' their practice by applying and adapting it to meet the needs of specific mothers. Knowledge of individual situations challenges consideration of the applicability of procedures accepted as routine in the hospital. This forces an identification and application of principles rather than rote delivery of standard procedures, thus combining the 'art' with the 'science' of midwifery practice. In promoting a task rather than person orientation, the development of such skills is not facilitated within hospital-based practice.

The second organisational feature, autonomy, is seen to be crucial for the development of a way of working that meets both the needs of the mother and the midwife. Autonomy relates to 'quality' and 'flexibility' – of care provision and lifestyle. In being given autonomy of practice midwives are no longer controlled by a hierarchy imposing particular routines that meet the needs of the institution rather than mother or practitioner. Instead, the expectation of what is to be achieved is defined but how this is to be achieved, within the limitations of accepted midwifery practice, is within the midwives' control, to be negotiated with mothers and their partnership. This enables midwives to find ways of working that suit them personally.

'Ownership' of time was seen to be one of the defining features of autonomy. When given back 'their' time, with the constraints of duty rotas, unsocial-hours claims and fixed clinics removed, caseload midwives are able to use it in a way that best suits

themselves and their mothers. This is more than just a 'convenience' but affects quality of care, for example: by facilitating home visits in early labour that support the physiological time of birth rather than controlling it in hospital through routine intervention.

Autonomy also enables midwives to engage in their work, particularly in the decisions they make concerning care provision. It encourages an involvement of the midwife's self, allowing a creative aspect of their work to emerge, something which is suppressed by routines and the expectation to follow imposed protocols. The potential is for more appropriate care for mothers and greater satisfaction through a realisation of personal expectations and self-actualisation for the midwife.

The third, and this study would indicate fundamental, feature of the model is continuity. Caseload practice in this model is synonymous with continuity, no 'false' distinctions between continuity of care and carer being drawn. One midwife takes responsibility for providing midwifery care to a set number of mothers and, as far as is reasonably possible for individual practitioners, provides or supervises that care. This feature proved the basis on which the issues of responsibility and autonomy are actualised and hold meaning. Without it neither are as significant.

Continuity also facilitates the delivery and refinement of midwifery care. It gives meaning to the midwives' work as familiarity with particular situations facilitates provision of appropriate care. Repeated contact enables assessment of care, facilitating modification or change as indicated. Time spent in planning and preparation with each mother, particularly about birth, becomes an 'investment' where midwives also benefit. In the partnership arrangement, midwives have an assurance that care discussed will be provided, most likely by themselves, giving them the opportunity to assess the preparation and the satisfaction of recognising when it was appropriate and thorough.

Continuity also enables the development of 'meaningful relationships' if desired by both parties. The repeated contact facilitates the process of midwife and mother getting to 'know' each other and the individuality of both can be acknowledged and appreciated rather than denied. This holds the potential for the development of a more engaging and fulfilling role for midwives.

However, the social component of 'being with woman' as needed, also raises the possibility of the development of dependency relationships and inappropriate

Knowledge

Obstetrics as the 'authoritative knowledge'

Knowledge has long been recognised as an important source of power. For Parsons (1949), functionally specific knowledge to which there was controlled access formed a major contribution to professional authority. A less structuralist approach taken by Foucault (1980) highlighted the role discourse played in the distribution and control of power. Foucault considered that power worked through discourse to shape popular attitudes towards phenomena. Expert discourses were established by those with power or authority, and countered by those with competing expert discourses. Thus discourse may be used as a powerful tool to restrict alternative ways of thinking or speaking, and knowledge becomes a force of control (Giddens, 2001). In reporting her study of information-giving during labour, Kirkham (1989) warned how midwives even lacked the language appropriate to midwifery; the discourse was medically framed and constituted in a manner that denied the reality experienced by mothers and some midwives, for example the notion of 'transition' in labour (Kirkham, 1989:134-6). Similar linguistic omissions denying the more 'feminine' skills involved in nursing, and the importance of 'intuitive' as opposed to theoretical knowledge, have been raised in feminist analyses such as Davies (1995).

As outlined in the description of the context of the study, access to and control over the 'discourse', or authoritative knowledge (Jordan, 1993), of childbirth formed one of the principal sources of medical power in the conventional service, constituting the hegemony of the unit. Over time knowledge proved a source of power for caseload practitioners, and they began to develop a heresy to the hegemony (Davis-Floyd, 1999) in offering an alternative approach. However, as the majority of caseload midwives had trained within this environment, gaining confidence in thinking and practising in alternative ways took time to develop.

In the hospital one of the main reasons for the medical domination of the service, as described in the context chapters, was their knowledge base. For career-obstetricians working in a recognised centre of excellence, knowledge acquisition and generation was fundamental to the doctors' work. This contrasted to the relatively weak body of midwifery knowledge that was available and enacted within the hospital. Although a number of midwives had been practising for many years, as both Schön (1983) and

Benner (1984) noted, experience does not necessarily indicate expertise. Unlike the medical staff, the senior midwives worked as managers and were not actively involved in teaching or research. The lack of midwifery expertise, in the form of a role-model or library, and the lack of a forum, formal or informal, for discussion or development of midwifery knowledge further impeded this situation. Midwives were seen to be 'treading water' just to keep abreast of work, as opposed to actively reflecting on practice and developing their expertise. As an established practice, doctors rather than midwives formed an important source of knowledge acquisition for the midwives. These features, summarised in Table 18, contributed towards obstetric knowledge being the authoritative basis from which all staff worked.

The development of a medical dominance of knowledge was, in a Foucauldian sense, colluded with by the midwives. Pressure of work, lack of midwifery confidence, and with no strong leadership to the contrary, the hospital midwives became very skilled in particular areas and adept with the technology. In effect they had become, as the student midwives defined them, "*obstetric nurses*". This description did not apply to all the midwives, a few of whom were strong in 'midwifery'; but the corporate body of midwifery knowledge was weak and midwives did not strive to overcome this, a situation similar to that found by Kirkham (1989).

The perception held by many of the midwives that the doctors, as experts in obstetric knowledge, knew best was exemplified in the situation described in Box 5:

Box 5

Personal experience: A senior registrar was explaining a new research protocol to the midwives who were expected to implement it. Several ambiguities became apparent to me during the explanation. However, when as an E grade midwife I sought to clarify these, a senior sister 'quietened' me reassuringly with a gentle hand on my arm saying "*shush, he knows what he is doing, he knows best*".

Field-note comment: Although the potential for compromising the research data was clear to me, a 'doctors know best' attitude dominated. Why? Because they were perceived to have authority and be experienced in research? How far does the exercising of such perceptions over-ride good practice in other aspects of care? What inhibits a 'team-work' attitude in such situations?

Source: reflective practice notes; delivery unit; 1996

**Table 18: Knowledge development and the practitioner:
structural and motivational features**

Features of knowledge development	Doctors	Hospital Midwives	Caseload Midwives
Motivation for knowledge development	Career orientation. Clearly defined career structure. Expectation of training. Highly motivated.	Very limited career structure. Professional requirement but minimal check. Personal interest. Limited motivation.	Personal involvement and responsibility for individual care of caseload. Direct feed into care. Strongly motivated
Ease of local access to knowledge	Medical library on site, with librarian & computer resources. Senior colleagues active in lecturing and research.	Access to on-site medical library. Occasional midwifery texts held on wards. Senior colleagues in management; active midwifery lecturers not on site (apart from L-P with project). Ready access to obstetricians.	Personal control over time and space facilitates accessing university midwifery libraries or personnel, as desired. Lecturer-Practitioner initially attached to project.
Structured learning arrangements	Regular medical seminars and presentations.	No regular in-service training. Ad hoc seminars arranged. Invited to some medical meetings. Attendance at meetings limited by shift hours and pressure of work.	Group peer-review discussions. Facilitated to organise seminars as need identified. Attendance at these enabled by personal control over work arrangements.
Knowledge generation through research	Career focus or expectation of training. Active involvement in selection, design and process of research.	No requirement. Involvement through data collection for medical staff and for audit. No involvement in selection, design or analysis.	Active involvement as participants of major research project requirement of job. No involvement in design or analysis.
Focus of knowledge development	Medical aspects of childbirth. To become experts in field of obstetrics.	Medical aspects of childbirth. Care of women in hospital. Become skilled 'obstetric midwives'	Holistic aspects of childbirth. Care of women per se. Become skilled midwives.

Challenges to the hegemony

Nevertheless this tendency towards unquestioning acceptance was not universal and appeared to diminish over the course of the study. The impetus for this change was likely to be from two sources: the presence of degree-level midwifery students with a more questioning attitude, and the developing confidence of the caseload practice midwives offering an alternative source of expertise.

The centrality of university education for professional status was noted by Talcott Parsons in 1937 (cited in Bryan, 1999). However, as Kirkham (1996) detailed, a body of 'midwifery' knowledge had yet to be formalised, and much had already been lost. As this was slowly being developed, from the anecdotal and experiential to research-based knowledge, the new midwifery degree curriculum drew heavily from obstetric and sociological disciplines. Nevertheless, critical analysis was integral to both diploma and degree level courses and, familiar with much of the current evidence, the new students began to question practice, particularly that which was not research-based. Initially this generated some irritation amongst the more experienced midwives but over time students helped influence a change in attitude and became accepted as a useful source of knowledge. This was most noticeable in caseload practice where, particularly towards the end of their six-month secondment, during observation of the group meetings students were seen to actively participate and were both seen and heard to be valued as contributing members of the team.

The students' university-level knowledge base was particularly helpful in challenging inconsistent aspects of the hegemony. The national impetus for research-based practice promotes the image of an exact science, rather than the reality of 'shifting sands' with research-based knowledge being 'the best at present' and often contested. Nevertheless, even where evidence was considered strong, a lack of medical agreement on certain issues was apparent; for example the timing of induction of labour following spontaneous rupture of membranes or for post-maturity. Some consultants disagreed with the hospital guidelines and demanded different policies be followed.

Whereas such inconsistency had previously been 'explained' by the hospital midwives as the idiosyncrasies of particular consultants, it became apparent that these were increasingly being questioned, in private if not directly to the individual concerned. Some of the caseload midwives were particularly vocal, questioning amongst

themselves why particular consultants were "*allowed to get away with*" adhering to practices which were not "*up to date*". A 'theory:practice' gap was identified by midwifery students in medical as well as midwifery practice. Although the students were not well placed to challenge senior obstetricians, and merely complained in frustration, such practices were increasingly called into question by the midwives, particularly the caseload practitioners who learnt to defend changes in their practice with clear arguments and research-based evidence.

Developing caseload knowledge: a new source of power

Although originating from the generally subservient position of midwives outlined above, over time the caseload midwives' knowledge base became very different. This affected their attitude and the sense of power they demonstrated.

All the caseload midwives identified an enormous increase in their knowledge, highlighting their initial steep learning curve as they gained experience and constantly exercised their skills in all areas of midwifery. This way of working forced them to translate theory into a practical application in a way that made sense to themselves and their women. An understanding of individual circumstances caused them to 'situate' their knowledge, they had to 'apply' it, to contextualise it, and in so doing they gained a greater understanding of the issues involved. In doing this they were also able to learn from mothers, as suggested by Kirkham (1996).

Moreover, the midwives had the motivation to seek out knowledge in their desire to provide good care for 'their' women. Personal control over their work gave them greater flexibility than their counterparts working in hospital in their ability to find information; not tied by time or place they could visit the university library or meet with particular 'experts' during their working day.

Knowledge development was supported by the philosophy of the unit in which the project was initially based; admitting to not knowing something was considered acceptable if addressed. Midwives were encouraged to identify their learning requirements and their access to appropriate resources was facilitated rather than 'delivered' to them. The importance placed on peer review in the job descriptions was to encourage a 'learning from each other', with the aim of developing their body of midwifery knowledge.

The sense of responsibility engendered by 'owning' a caseload, control over working arrangements, and the facility to be responsive and reflexive rather than merely reactive, offered the caseload midwives greater opportunity to develop their expertise and achieve the 'expert' status defined by Benner (1984). Also, this enabled them to develop an 'authoritative knowledge' (Jordan, 1993) in midwifery practice that had not been developed within the community midwifery service.

The change in attitude and knowledge that was demonstrated by the caseload midwives generated both resentment and respect amongst their colleagues. Resentment was expressed mainly by those with minimal power themselves, in particular the junior doctors and 'junior', although experienced, hospital midwives. More senior medical staff initially considered the caseload midwives to be *'bit above themselves'* but over time accorded them some respect, and reported valuing the midwives' input into the planning of care.

This change in attitude partly reflected the development of trust and an acknowledgement of the caseload midwives' competence. It was also recognition of the midwives developing and displaying a sense of authority concerning the mothers on their caseload; an authority that was derived from the autonomy and responsibility exercised and knowledge they had developed. Nevertheless, this authority was not 'given' but 'earned', and most effectively exercised where trust had been established, as identified observing the doctors' round on delivery unit (see chapter 5).

Trust

Trust is an essential characteristic for successful working relationships (Kirkham 1999) and was identified as a sub-theme in the analysis of this study.

The centrality of trust in post-modern society was highlighted by Giddens (1990), who considered it fundamental to even the most basic of activities such as going upstairs or driving a car; trust becomes important when information is absent. In the maternity service trust appeared to act as the vital lubricant that enabled the smooth working of a complex system involving a number of practitioners. For caseload practice this was observed in several ways:

- **Doctor to midwife:** 'Testing' of midwives was both admitted to by a senior registrar and noted as a common feature during the observational study of the

doctors' delivery ward 'round'. Presentation of a succinct and relevant summary of the case by the midwife, with an outline of a clear plan of action, often resulted in a cursory visit and the midwife and mother were left alone. Inappropriate or lack of response on the part of the midwife resulted in them being watched with care and medical involvement in the case was likely.

Senior doctors, who tended to remain on site for a number of years, got to know the caseload practitioners quite well and reported quickly deciding who to trust. The more junior doctors, who rotated frequently, rarely learnt to know the caseload midwives; several appeared to hold the system, and midwives, in some apprehension.

- **Midwife to mother:** Midwives reported that, in learning to trust mothers they were then able to relax more. Trusting that women could and would call if they had a problem, and trusting women to be able to give birth normally were important features of the equality of relationship formed. The midwives also learnt to trust themselves and that good care did not necessitate constant action (Menzies, 1970; Benner, 1984). They reported that on occasions their greatest action was in deciding when not to act, particularly during labour, but remain quietly aside and 'allowing' the mother to continue as she wanted. This form of action through 'inaction' was considered extremely difficult at first, reflecting the original philosophy of 'management' of labour where some form of intervention was the norm. However the midwives learnt to trust the value of their 'being' rather than 'doing', their 'presencing' (Benner, 1984; Fleming, 1998) as an important constituent of good midwifery care.
- **Mother to midwife:** Midwives expressed surprise at the time it took women to disclose personal issues such as previous abuse. This suggested that trust was not an inevitable part of the relationship, however close it appeared to be, but needed to be worked at. As women knew their midwife better they revealed more about themselves, and so empowered the midwives to provide more appropriate care.
- **Midwife to midwife:** Trust in each other proved an important feature of the partnership and group practice. Knowing their partner worked in a comparable way, and that when not present appropriate care would be given to their women, enabled the midwives to relax when not 'available'. Problems occurred if the partnership worked in very different ways or when relationships broke down within the partnerships or group.

As the vital lubricant for a service where all parties were over worked, everyone needed to learn to trust each other. In caseload midwifery, a sound knowledge base and reliability remained essential yet it was also imperative that individuals earned the trust of their colleagues and clients and worked to maintain it. Once gained, trust proved an empowering feature of the midwives' practice.

Professionalisation of the oldest profession

An ill-fit

Acknowledgement of the degree of autonomy achieved and the development of a specifically midwifery body of knowledge demands consideration of viewing the implementation of caseload midwifery as a form of professionalisation of midwifery (Sandall, 1996). This view is slightly ironic given that midwifery has been conceived of as 'the oldest profession', emerging as an essential occupation that developed as bipedalism evolved (Trevathan, 1997).

As Freidson highlighted, the various analyses of 'professions' present such confusion and contradiction that any sense of unanimity of meaning is "*more apparent than real*" (Freidson, 1977:15). Nevertheless, the occupation of midwifery which developed since the 1902 Act fitted Williams' (1993:8) summary of the key characteristics most commonly cited; these included:

- skill based on theoretical knowledge
- the provision of training and occupation
- tests of the competence of members
- organisation
- adherence to a professional code of conduct
- altruistic service

Moreover, it is Friedson's (1977:23) additional criteria of a profession being "*free of the authority of others over their work*" that, on a day-to-day practice basis, clearly separates midwifery from nursing. Officially and legally, midwives are stated as being autonomous practitioners in the realm of uneventful, 'normal' childbirth. This position had been undermined by the hospitalisation and increasing medicalisation of childbirth,

as discussed in chapters 3 and 4, but caseload practice enabled midwives to reclaim that competency. This contrasts to nurses who are bound into an occupationally subordinate position to doctors; although having claimed many 'professional' attributes they remain, in Friedson's terminology, "*paraprofessional workers*" (1977:25). On this basis it could be argued that caseload midwifery has claim to 'true' professional status.

However, midwifery, and caseload practice in particular, sits ill with the ethos of the traditional professions. These have a masculine orientation (Hearn, 1982) and, although purporting autonomy of practice, as Davies (1995) highlighted, they require major input in the form of preparation and servicing in order to function. Usually this is provided by the more 'feminine' occupations, such as secretarial work or the semi-professions (Etzioni, 1969) like nursing. For Davies (1995), the dilemma for the professionalisation of nursing, and by extension midwifery, lay in this gender orientation and its denial of the 'feminine' nurturing features that form the basis of caring work.

Moreover, a further criticism of traditional professionalisation suggests the demands of the occupation itself may take precedence over the client. In her consideration of the medical profession and the work of the General Medical Council (GMC), Stacey (1992) criticised the restrictive and defensive practices that led to doctors putting the profession before the public. Such questionable prioritisation, as acknowledged in the Bristol Inquiry (Diamond, 2001), lead to public outcry and cause great distress.

In condemning the GMC as an outdated 19th century phenomenon adhering to a set of "*collective illusions*", Stacy (1992) considered the need to address the lack of insularity and secrecy that, under the guise of confidentiality, cloaks the majority of professional consultations. She also suggested that the idea of a one-to-one relationship with patients needed to be relinquished in recognition of the contribution others make to health and healing (Stacey, 1992), a movement which might also decrease patients' vulnerability (Atkinson, 1995). The warning holds resonances for individual midwifery caseload practice, although the problem was addressed by the importance the midwives themselves placed on working collaboratively as a result of their experience.

More central to the debate lie the issues of the nature of professional knowledge and the power relationships involved with its generation and protection.

It is widely accepted that 'expert knowledge', as a systemised theoretical body of knowledge, is the essential foundation on which professional status is built (Parsons,

1949; Freidson, 1977). The theoretical basis of this knowledge is rationalism, a belief in scientific objectivity, that knowledge can be certain and absolute, and has status and origin independent of humans (Popper, 1972). Yet knowledge is not absolute, but socially constructed and changes as new information is discovered (Williams, 1993; Chalmers, 1982).

Control over the focus of knowledge development has, until recently, been held tightly in the domain of the relevant experts or professions. There, bias of personal interest or patronage can influence the acceptability of new research proposals and allocation of limited funding, successfully dictating the agenda and focus for knowledge development in that field.

As Williams (1993) commented, although there is no one 'ideal type' of profession, and they may change over time, a key element of the professional-client relationship is one of 'mystification'; professionals promote their services as esoteric. In laying claim to their specialist knowledge, professionals offer a prescriptive service; they know better than their clients, prescribe what the client needs to know, and, in passing on that information, expect compliance as well as a degree of recognition and respect from their client (Friedson, 1977; Hugman, 1991; Williams, 1993).

Creating dependency on their skills and reducing the areas of knowledge and experience they have in common with their clients, enables professionals to increase the 'social distance' between themselves and their clients - and so gain increasing autonomy (Johnson, 1989). For Atkinson (1995) the asymmetry of the relationship is exaggerated to the point that the client becomes not the beneficiary but the *victim* of the consultation (author emphasis). The power base of the professional is affirmed.

These concepts of 'objective knowledge', 'mystification' and 'social distancing' are at complete variance with the ethos and practice of caseload midwifery. As previously discussed, the uniqueness of each woman was recognised in a relationship between midwife and mother based on the exchange of information. Mutuality and interdependence was stressed with the midwives striving to promote independence rather than dependency in their clients.

Aligning midwives with traditional professionalism would undermine the essence and strength of their work. Moreover, traditional professionalism is increasingly being questioned (Schön, 1983; Giddens, 1990), and there is a developing lay involvement in

‘expert’ knowledge evaluation and generation. The traditional position of the professional is under threat.

Development of the ‘lay-expert’

A growing disenchantment with the claims of ‘grand experts’ and ‘absolute truths’ was noted by Giddens (1990) and been demonstrated in public disputes over ‘experts’ advice concerning ‘BSE’ and genetically modified foods. Concurrently, an apparent diminution in the power of professionals, particularly doctors, has been introduced with the development of a consumer and managerial culture in welfare provision (Mason, 1995). Changes in policy have been designed to give more power to ‘clients’, and make services more efficient with the development of managerialism and the purchaser:provider contracts. The power of professionals who provided the services have been contained to give users of the welfare state, ostensibly, a greater voice in how it is run. This has been extended to an involvement in research undertaken on NHS premises with the co-option of lay-people on NHS research committees (SAGCI.in NHS.R&D, 1998).

A “*democratisation of science*” (Bloor, 2001) offers the potential to tackle public priorities, address public mistrust, and enrich scientific thinking by the incorporation of diverse perspectives (Irwin, 1995), thus challenging the ‘gate-keeping’ practices of professionals in knowledge acquisition - a situation the internet has helped achieve. ‘Lay expertise’ has developed in a variety of areas and, at times, challenged the professional orthodoxy (Bloor *et al*, 1998), occasionally becoming accepted as the scientific orthodoxy (e.g. Miners Lung and pneumoconiosis, Bloor, 2000). The co-presence of medical expert and alternative expert should, Bloor (2001) suggested, increase the effectiveness of clinical decision-making. Nevertheless, the degree to which lay influence is achievable within a professional forum has yet to be established.

Childbirth offers a contrasting perspective on the development of lay-expertise. Reliance on professional advice should be minimal for healthy women undergoing a normal physiological process. However, ‘lay’ expertise built up over the millennia has, in the last century been appropriated by the professions (Kirkham, 1996). Childbearing women in modern society are further disadvantaged by lacking experiential knowledge about childbirth. With fewer pregnancies and the majority of deliveries ‘hidden’ away in hospitals, women have minimal experience compared to their multigravid counterparts in resource-poor countries. They also have a major emotional investment

made into their one or two planned pregnancies, with an ensuing heightened desire for perfection (Giddens, 1999). Although successful childbearing does not necessitate medical intervention in the majority of cases, mothers are forced to seek professionals' assistance to access the resources of the NHS and social service benefits, and almost invariably couples turn to experts for advice and guidance.

It is in this slightly unusual environment, where 'normality' has been forced into a reliance on the professions, that a counter movement has developed (Ashton, 1992) and received subsequent governmental support, in their acceptance of the recommendations of *Changing Childbirth*. Increased consumer involvement in care is now standard government policy.

Nevertheless, Bloor (2001) was sceptical that professionals would relinquish power by encouraging lay involvement in their field of expertise, having observed how clinicians resisted patient attempts to influence diagnosis and treatment by developing various strategies on patient exclusion (Bloor, 1976). A study of the 'patient-centred medicine' movement in general practice, which sought to empower the patient, found the consultations to be "*artfully contrived, bounded and orchestrated by the practitioner*". It involved particular skills which could be learnt, and thus became "*technical-rational solutions, consciously engineered and maintained by the practitioner*" (Steward *et al* 1995, cited by Bloor, 2001). Such findings augured ill for the aims of the maternity service, as recommended in *Changing Childbirth* (DoH, 1993). The initiative to improve mother's input into their care by providing information, proved equally problematic.

The MIDIRS informed choice leaflets were designed to facilitate consumer involvement in decisions made about their care, by providing research-based knowledge to inform their choices. Evaluation of the initiative indicated cultural inertia and constraints on midwives' time contributed towards the delivery of "*standard packages of information*", as opposed to involvement and a meeting of individualised needs as envisaged. This resulted in "*informed compliance*" rather than informed choice (Kirkham and Stapleton, 2001). Knowledge and power may be closely linked but such links are socially constructed, not automatically established. In the informed choices study organisational and cultural features were seen to mitigate against the effectiveness of the information leaflets.

Not all clients may wish to be actively involved in decisions about their care, preferring the professional to assume responsibility; alternatively they may lack motivation to enter an informed debate over treatment options. In post-modern society, the increase in technology and in expectations, with a concurrent diminution in actual experience can promote a 'professionals know best' attitude, in which people place trust in the expert systems of which they have little understanding (Giddens, 1990).

Caseload midwifery: a new professionalism

The ethos behind the changes in the maternity service and the development of caseload midwifery has been to enable childbearing women to be more actively involved in decisions concerning their care. In the sense that they gained autonomy and developed a specific knowledge base relating to their work, caseload midwives were developing a form of professionalism not experienced within conventional models of practice. This professionalism appeared very different from traditional models, particularly in the relationships the midwives formed with their clients. However, it fitted closely with the ideas raised by Schön (1983) and Benner (1984) of a reflective, expert practitioner whose work defined a new form of professionalism (Williams, 1993; Davies, 1995).

This 'new professionalism' was sited within a radically different knowledge system that emerged from the synthesis of two components: the practitioner's knowledge and the client's knowledge, in much the way posited by Kirkham (1996).

As Schön (1983:296) noted, the practitioner must be "*credentialled, and technically competent*"; a robust and current knowledge of research-based midwifery practice is the minimal requirement. However, 'expertise' is only developed and honed through the application and reflection-in and after-action of such knowledge in Schön's (1983) "*swampy lowlands*" of real life. For the caseload practitioners, these 'swampy lowlands' constituted the reality of mothers' lived experiences as opposed to the institutionally regulated 'real life' in which their hospital-based colleagues worked. The differing situations honed very different forms of expertise.

It is likely that, working with situated 'knowledge' of the mothers' they care for, caseload midwives could more readily achieve the "*connoisseurship*" (Polanyi, 1958) that Benner (1984) considered crucial to the expert clinician. From the Latin *cognoscere* : to know, this finely tuned skill involves the recognition of subtle changes, the significance of which are often only appreciated with knowledge of past history and

current situation. Such "*perceptual recognitional ability*," Benner (1984:5) suggested, is a skill in clinical judgement that remains overlooked in the quest to learn the latest technological procedures. However, the movement away from task-orientation to the more individualised care of caseload practice clearly offers greater potential for its development.

Nevertheless, the new professionalism involves more than the development and application of this knowledge-based expertise. Used appropriately the practitioner must, in anthropological terms, seek the emic perspectives of each client they are working with, and be able to communicate appropriately with them. Once these perspectives are understood, and their views, fears, hopes and wishes acknowledged, care can be appropriately planned together, and provided.

In aiming to maximise the patient's participation and control in their situation, Benner (1984) suggested practitioner should seek to help them use their inner resources, valuing and drawing on the input of the family as additional resources in the formation of therapeutic relationships. Such experiences are the lived reality of midwives and traditional birth attendants in resource-poor countries who, lacking access to technological assistance, support women in giving birth physiologically. They appeared to have little place in the time-constrained environment of the hospital studied, where medicalised childbirth promoted the powers of technology rather than of mothers themselves.

For the practitioner, dependence on the client's participation does not entail an abdication of responsibility but the additional skill involved in identifying and utilising the resources available from the clients themselves. It presents an alternative approach to the use of expert knowledge, based on partnership. One way transmission is replaced by two-way transaction, with the professional building on the existing knowledge and client's experience according to client's perceived needs and professionals' response to these (Williams, 1993).

However, to achieve this situation the practitioner's skills in accessing client knowledge through the formation of appropriate relationships becomes paramount. The suggestion that the relationship the practitioner formed with their client could be more important than their role as expert was suggested by both Walmsley *et al*, (1993:6) and Schön (1983)

Bloor (2001) drew on the work of Richard Korn (1964) to highlight the political perspectives behind the expert-client relationship. In providing a clear comparison between the traditional models and the theoretical model suggested Irwin (1995), Bloor foresaw the potential of the new professionalism that has been identified here in caseload midwifery; see Table 19.

No longer the professional seeking to impose their views, the midwives' role changed from one of controlling to one of supporting and of sharing knowledge, in a way similar to that in education advocated by Freire (1972).

Table 19: Alternative Models of the Social Expert

	Expert as Operator	Expert as prescriber	Expert as co-learner
Action of expert	Does <i>to</i> client what client cannot do	Does <i>for</i> client what client cannot do for himself (sic)	Transactional sharing of learning Does with the client what the client can ultimately do for himself (sic)
Role of client	Total passivity Client as object	Dependency Client as dependent	Active participation Reciprocity, client as colleague
Relational aspects	Dominance-submission	Superordination-subordination	Mutuality
Typical statuses	Surgeon-body	Ruler-subject Parent-child	Siblings Friends

Adapted from Korn 1964:588 by Bloor, 2001

From this perspective, the most important foundation of professionalism is the 'self' of the professional - the ways in which they relate to their client and the interpersonal skills they bring to the transaction. As discussed in the previous chapter, this engagement of 'self' had emerged as a important theme in this study from the caseload midwives. Williams (1993) suggested 'professional' practice now has less to do with the application of esoteric knowledge and more to do with intuition, common sense, techniques for helping and interpersonal skills. Theoretical knowledge loses its centrality in the professional-client relationship, moving from a position of dominance to one of support. The shift also moves from viewing the foundation as scientific rationalism to recognising it as an art (Williams, 1993; Davies, 1995). No longer the

dominant actor, the 'new professional' "*exhibits the humility of interdependence*" (Davies, 1995:150).

This strikes at the heart of traditional professionalism. For professionals who trained many years to acquire a body of expert knowledge, passed examinations to gain qualifications and entry to the profession, it challenges the pre-eminence of their professional knowledge-base, constituting a grave threat. Power is removed from them and handed to the client; the base of their power is now located with their clients rather than their professional body (Williams, 1993).

Characteristics of the new professional practitioner were summed up by Davies as:

- Neither distant nor involved but *engaged*
- Neither autonomous nor passive/dependent but *interdependent*
- Neither self-orientated nor self-effacing but accepting of an *embodied use of self* as part of the therapeutic encounter
- Neither instrumental nor passive but a *creator of an active community* in which a solution can be negotiated
- Neither the master/possessor of knowledge nor the user of experience but a *reflective user of experience and expertise*

(Davies 1995:149-150 author emphasis)

Such characteristics hold clear resonance with caseload midwifery practitioners.

Problem areas for midwives and mothers

This new form of professionalism, as observed in caseload practice, could increase the vulnerability of each participant. For midwives this was particularly noticeable in two situations: adverse outcomes, and rejection of professional advice.

It was inevitable that, during the course of the study, adverse outcomes to some cases would occur. Concern was expressed by both senior obstetricians and midwives that the caseload practitioners might become too emotionally attached to their women and have difficulty continuing to provide care whilst emotionally coping with such 'disasters'. The reported experience of the midwives was the reverse, as discussed in the preceding chapter, supporting Benner's hypothesis that engagement rather than distancing techniques are psychologically healthier for practitioners (Benner 1984:164).

This new professionalism is built on a mutual respect between midwife and mother. Nevertheless, respecting the autonomy of women may present a problem if they are determined to follow course of action that is considered dangerous by the practitioner. Whilst obstetricians can strongly advise a particular course of action and withdraw care

if the mother refuses to accept it, midwives are obliged to provide care whatever the circumstances; this may place them in difficult situations (Harding, 2000). The caseload midwives talked about the advocacy role they played for their mothers, particularly when there was a potential clash with medical opinion. In general the tensions appeared resolvable, although the midwives reported feeling 'piggy in the middle' and being the recipient of medical frustration with some mother's choices.

In some situations, the midwife may understand why a mother adheres to a particular course of action despite clear guidance to the contrary, causing a reassessment of the clinical advice, as Lesley Page illustrated with her case, Jane (Page, 2000:7). Benner (1984) suggested the use of this contextual knowledge above and beyond the scientific is a feature of the expert practitioner. However, difficulties lie when there is lack of support, and judgmental comments are made by colleagues (Kirkham, 1999). Focusing only on the clinical issues of mothers transferred into hospital, professionals condemn the clinical practice of the midwife involved rather than offer the support that may be needed.

Such situations occurred during the course of the study, involving both caseload and community midwives. In all such dilemmas midwives have a duty to liaise with their Supervisor of Midwives; for the caseload practitioners, additional support was available in the form of the Lecturer-Practitioner who attended with the midwife involved in 'difficult situations' (see box 6).

Box 6

Précis of notes:

Discussion over lunch with project Lecturer-Practitioner (L-P) concerning a home delivery which the L-P had got called to when the parents refused advice. They were determined to stay at home despite being informed of the risks that had developed (thick meconium, prolonged labour with minimal progress).

I had met the L-P the following morning when she had been raging angry about being put in the position of having to stay and deliver a baby at home when there were strong indications for hospital transfer. In the end the baby came out screaming, all was well and the parents felt justified in their decisions. The L-P felt they had been very lucky.

The delivery ward consultant joined us at lunch whilst we were discussing some of the related issues. S/he commented on how lucky doctors were in being able to walk away from these situations, whilst midwives legally had to stay.

Note: is such understanding demonstrated in action?

Source: field notes: canteen chat 1996

Although the model of care was set up to enable women to have more control, an inherent danger lay in midwives becoming a powerful group, using the potential for dominating women in the guise of friendly service. Foucault (1980) noted pastoral care as the premier technique of power in late modern society, whilst Benner (1984:216) detailed the potentially negative power of caring, suggesting that “*nursing without caring is powerful and devastating*” with possibly harmful results for the patient, a situation discussed by McCourt *et al* (2000).

Although such demonstrations of negative caring were not observed during the study, the potential cannot be denied. However, early in the project the midwives identified the danger of their clients developing dependency relationships. In strategizing to avoid these, the midwives talked about how they tried to empower women by not doing but guiding, providing information and contacts to support women in their action. Some midwives, particularly those serving the needs of a relatively deprived community, considered they were able to offer their women a positive role model.

Both these problem areas are likely to be minimised if true mutuality and respect become the basis of the practitioner-client relationship. Midwives aligning themselves with traditional professions may not necessarily be to the advantage of mother or practitioner. This study of caseload midwives supports Hugman’s (1991) suggestion that a new ‘democratic’ professionalism, creating partnership and participation, empowers both users and the professional practitioner.

Nevertheless, the resources of the hospital continued to be used for some elements of care in the majority of cases, subjecting both mother and midwife to the controlling environment of the institution. As Foucault noted (Giddens, 1987, 2001) time and space are used as subtle forms of control within organisations. This phenomenon, was seen to have important implications for the caseload midwives so explored in detail in the following chapter.

Chapter 10

TIME: THE ULTIMATE CONTROL

"To practice the science of medicine and analyse and treat the disease the physician distances himself or herself in time from the patient and treats the patient as allochronic, in another time... To practise the art of healing the physician meets the sufferer in his or her own time, as a coeval." Frankenberg (1992:10-11)

In analysing the adaptations carrying a caseload demanded of the midwives, it was apparent that particular structures that had become separated in 'modern' society became fused again. The role and person of the midwife became one, and the professional:client dichotomy became a relationship of mutuality where the expertise of both midwife and mother were valued. Such fusion presented a radical alteration to the way caseload midwives worked.

However, perhaps the most fundamental fusion they experienced related to their use of time. This necessitated a deconstruction of the 'modern' way of compartmentalising time, returning to a more 'traditional' way of conceiving and using it (Thompson, 1967). Frankenberg (1992) indicated that a different use of time was involved in the practice of the science or the art of 'curing'. So it was in caseload midwifery. The different way of using their time enabled midwives to meet mothers on a level that acknowledged and facilitated the physiological timing of childbirth. Nevertheless, this change conflicted with the institutional concepts of time and the way time was used by others, generating tensions.

Ideas about time, and the expectations generated by these, influence the way people live and relate to others. An understanding of the way time was used, both within the hospital and when carrying a caseload, will help an appreciation of the very radical differences between the two models of practice. It may also help explain some of the problems experienced, by all groups of staff, particularly in the early days of the project. Those that work in the maternity services are also part of a social world, therefore the implications of such change were wider than the immediate work context. To fully appreciate the impact it is useful to consider the notion of 'time' itself and the influences on the ways this has been constructed in 'western' industrialised society.

Concepts of time

Time is often thought to be a universal concept, one of the few immutable truths that help provide stability in an increasing complex world. The belief that the existence of the phenomena of 'time', and the way it is both perceived and measured, is constant through out the world is reinforced by constructs such as the International Dateline. Nevertheless, many writers have shown this assumption to be fundamentally incorrect (eg. Thompson, 1967; Whitrow, 1989; Priestley, 1964; Hall, 1959). Diverse notions about time have been identified, and the ways it is constructed, used and interpreted may hold widely differing connotations, both between and within societies (Bloch, 1977; Griffiths, 1999).

Such concepts may be mirrored in a society's language. For the Hopi, they were found to be embedded in their social life and behaviour rather than externalised as a precise category; they had no word for the concept of time in their language (Whorf, 1971). In contrast, the lineal, forward moving notion of time forms an integral part of the English grammar in adverbs and tenses; in the vocabulary, time is accurately divided into seconds, hours, days and it is metaphorically referred to as passing or flowing.

The ways in which time is conceptualised and used can communicate powerful messages. In English it has been externalised, is tangible, a commodity that can be 'bought' and 'sold', 'saved', 'measured', 'wasted', or 'lost'. It is compartmentalised, time is allocated for work, leisure and sleep, and it is used sequentially; it is valued objectively and personally, carefully guarded, and individuals becoming angry if 'their' time is unnecessarily wasted (Hall, 1959, 1976), ideas which, it will be seen, are interwoven within hospital work.

Such notions are not created individually but are "*culturally constructed and culturally represented*", forming collective representations that act as "*a mirror of that society's social reality*" (Durkheim, 1915). An understanding of how time was conceived within the hospital and within caseload practice reflect underlying notions that influence the nature of the services provided. However, as both were situated within the *durée* (Giddens, 1987) of daily life, this must first be addressed.

Time in modernity

The way time is conceived of and used in modern society had been strongly shaped by the influences of religion and technology. Judaeo-Christian beliefs stress the notion of irreversible time; 'switched on' at creation, to be 'turned off' in the future, and the 16th century Protestant work ethic (Weber, 1976), placed a high value on the industrious use of time for spiritual rather than material rewards. Such notions, reinforced by puritanical preachers and social reformers, were subsequently internalised during the Victorian era (Thompson, 1967), promoted with the 'professionalisation' of midwifery (Heagerty, 1997), and remain in the idea of nursing and midwifery sometimes being considered as vocational work.

The industrial revolution had a profound effect, with time's 'inexorable passage' being stressed by mechanisation that altered the rhythm of people's lives, negating natural distinctions of time and reducing the element of personal control over work. The need for synchronisation of labour meant increasing attention was given to time, with people being paid by the hour not the task. Wage labour, and the growth of usury equated time with money and distinguished between private and employer's time. Work became a distinct period of time, and time a currency not to be 'passed' but 'spent' (Thompson, 1967).

Scientific and technological advances have both enabled and demanded increasing accuracy in the monitoring of time. The widespread use of reliable artificial light has overridden the natural patterning of the day, with the positions of clock-hands rather than the sun or moon determining people's activities. From the Egyptian *clepsydra* or early water clocks to the most recent computer developments, monitoring of time has changed from mechanical devices to electronic ones that measure time in nanoseconds (a billionth of a second) (Whitrow, 1989; Hockett, 1973). Such divisions are not 'natural' inevitable phenomena but imposed, constructed in response to change or development in the community; they also change that society. For example: the replacement of the stagecoach by a precision railway necessitated the development of exact timetables; these in turn imposed a particular structure on time and space to co-ordinate the activities of a large number of people (Giddens, 1987). Increasing travel and communication have subsequently necessitated the adoption of a 'uniform' time.

Today, universal education inculcates a time discipline on all. 'Economic' time tends to dominate life, patterning its stages through infancy, learning, earning, retirement, each year (work and holidays) and each day, clearly dividing it into work and personal time – mentally if not physically. Diaries are no longer used to record events but to remind and structure them. The upsurge in the use of filo-faxes and palm computer organisers, and development of various training courses suggests that 'Time Management' has become an economy in itself.

However, "*the citadel of science, technology and positivism (which) ties us to chronological time*" may not be entirely advantageous (Priestly, 1964); machine efficiency does not guarantee maximum efficiency, as regularity fosters apathy and atrophy rather than innovative thought (Mumford, 1963). Also, pressures of tight time discipline are thought to have detrimental effects on mental and physical health.

Such concepts and their consequences are not universal.

'Traditional' time

Pre-industrial societies have been shown to hold very different notions of time, but for all practical purposes 'task-orientated' time is the major framework (Giddens, 1987; Priestley, 1964). With the stress on observed necessities, work is adjusted to the task not the time allocation, and there is minimal demarcation between labour and social activities. In rural societies, specific activities, rather than a clock or calendar, provide demarcating points in time. Routine daily activities divide the day, as in the notion of the Nuer's 'cattle clock' (Evans-Pritchard, 1969), local markets may give their name to the day on which they are held (Goody, 1968), months are named by the predominant activity of that period (Evans-Pritchard, 1969). The concept of seasons is derived as much from social activities as climatic change (Bohannon, 1967) and because a year is related to a cycle of tasks as well as the seasons its length is indeterminate (Smith Bowen, 1964).

Physiological time

Although occurring in societies dominated by specific notions about time, childbirth carries its own time – a physiological time that is imposed on the mother. She commonly ‘slows up’ towards end of pregnancy and may experience changes in sleep patterns. To a greater or lesser extent the expectant mother is being eased into having to use her time in a different way to meet the demands of a new-born that has yet to be socialised into a ‘daily routine’. Labour commences with no reference to what may be socially convenient, and the woman is delivered into motherhood at a pace over which she has minimal control. For millennia, ‘traditional’ birth attendants have supported and accompanied women during this transition, rarely attempting to control or subvert the timing of events that were physiologically inherent. This situation has changed radically in many societies (Davis-Floyd and Sargent, 1997). In an age where time has become inherently scheduled and commodified, it is not surprising to find such control being extended to the arena in which childbirth is now placed.

Use of time

Ideas about time are not homogenous to a society as individuals may favour particular notions. Also, in complex post-industrial society people move between models during their daily life, being forced to acknowledge different attitudes and concepts relating to time simultaneously. For example: the demands for strict time control placed on factory workers and the generally more relaxed demands of family life; a similar difference was noted within the hospital, between delivery unit and ward.

However, the dominant ideas become embedded within the culture of each society both reflecting and influencing the ways in which people think and behave. This may have serious ramifications as concepts about time are relative to societies, dictating how individuals conceive their world and relate to each other. Problems occur when the different sets of ideas about time clash, as when individuals move between countries or, it is argued here, models of midwifery, forming the basis for ‘cross-cultural’ misunderstandings (Carroll, 1990).

The ways in which ideas about time and its usage can be internalised and affect behaviour have been most clearly developed by Hall (1976, 1969, 1959) and are helpful in understanding the different nature of caseload and hospital midwifery practice. The 'task-orientated time' of pre-industrial societies, detailed above, is closely related to Hall's notion of poly-chronic time. This is characterised by several things happening at once and stresses the involvement of people rather than adherence to pre-set schedules (Hall, 1967, 1976). These characteristics may be seen to apply to caseload midwifery.

Modern post-industrial ideas of time are summated in his notion of mono-chronic time, and Hall (1967, 1976) stressed how use of this directly affects attitudes and behaviour. Undertaking activities separately and sequentially implies implicit and explicit scheduling. This involves according priority to people and functions, and so forms a classificatory system ordering life which is so integrated that it appears logical and natural, although it is not inherent in natural rhythms. Prioritisation implies a valuation, and thus the use of time acquires an implicitly recognised code; e.g. a call at 2am has more serious connotations than one at 2pm. Segregation of activities enables total concentration, but 'decontextualises' them and people may become disorientated if they undertake several activities at once. Relationships are intensified but then temporally limited, as in business meetings or hospital appointments, which are private but of fixed duration. Failure to observe the limit implies intrusion on another's schedule, and may be considered ill mannered or egocentric. Such ideas hold strong resonance with the hospital maternity service and help explain negative reactions towards caseload practitioners who worked within a poly-chronic timeframe.

In appreciating the changes faced by the caseload practitioners, an understanding of the way time was conceived and used within the hospital is important. Having come from this system the midwives would have internalised it to some extent. However, they were forced to rethink and develop different ways of using time in caseload practice.

Hospital time

Implications concerning the way time and space are used and controlled within institutions like hospitals have been highlighted by studies such as Frankenberg (1992), Foucault (1973), Goffman (1968) and formed the focus of Zerubavel's *Patterns of time in hospital life* (1979). A predominant feature of such work is an appreciation of the relationship between the control of time and status and power within the institution. For

Frankenberg (1992) time itself and the way it was used and controlled formed a definitive element in the practice of health care and healing. Such a relationship may hold particular implications for a maternity service that has been directed to provide mothers with increased choice and control (NHS.ME.EL(94)9).

Nevertheless, the ways in which time was conceived and used within the maternity service was different from that described by the studies cited. The institutional:real time dichotomy, described by Goffman (1968) and Foucault (1973), and the concept of 'illth' harmonising health and illness, suggested by Frankenberg (1992), proved tangential; birth rather than sickness is the central feature of maternity care. For many women, attendance at the maternity hospital was neither therapeutic nor custodial; the majority of clients were healthy women who could give birth successfully without medical intervention.

How then was time used by the maternity service in this study and in what ways did the new model of care influence the caseload practitioners' ability to practise the art and science of midwifery?

An uneasy alliance

In this study it became apparent that the hospital maternity service necessitated the merger of three, potentially competing, time frames: physiological-time, institutional-time and the personal-time of 'normal' daily life.

- Serving the needs of childbearing women, the *raison d'être* of the service was guided by the physiological time of gestation, of labour, and the demands of the neonate. The service had to be constantly available.
- Serving the needs of many rather than the individual forced a rationalisation and the development of 'institutional' time, as described below.
- The service was provided by, and for, individuals who lived in a world external to the hospital, governed by the complexities of 'normal daily life' and the notions of time described previously. Work or hospital visit remained but one component in these lives.

Within the hospital these time frames formed an uneasy alliance, resulting in a particular patterning to the day and to the organisation of work within it. The potential for conflict between institutional and personal time occurred throughout the hospital,

but those between physiological and institutional time were most apparent on delivery unit.

Although core staff working rotational duties or 'shift work' provided the 24-hour baseline service, institutional time gave the appearance of the patterning of activities of 'normal daily life'. Most categories of staff worked a modified 'office hours' regime, afternoon and evening visiting gave a social element to the day, whilst night time was period of quiet, reduction in noise and lighting being used to encourage 'patients' to rest. Nevertheless, it could be extremely busy at night and a reversal of the natural day:night work:sleep dichotomy was imposed by bright lights being kept on. This subversion of 'normal-daily-life' time by institutional time appeared unremarked by staff, and generally accepted by 'patients'. Time was less tightly controlled over weekends and bank holidays when routine work was avoided and a more relaxed atmosphere prevailed.

The division of time and labour aimed to ensure an appropriate number and skill of staff were available when most required; that it did not succeed was noted by the Audit Commission Report (1997). However, a clearly hierarchical pattern emerged. The association of flexibility and control over one's time being inversely related to status and power within a hospital had been highlighted by Zerubavel (1979) and clearly demonstrated here. Night periods were covered by more junior staff supported by senior or specialist staff working an on call system; the most senior staff, consultants and managers, were rarely seen at night unless called specifically for an emergency situation.

Although serving the needs of 24 hour physiological time, hospital time imposed a strict schedualisation. The day was divided and defined by the clock in the organisation of duty rotas, of clinic schedules and appointments, ward rounds, operation lists and inpatient meal times. These determine where people would be at specific parts of each day and helped ensure all necessary tasks were undertaken. In this manner, time served to regulate and create order out of complexity and, given the numbers of people involved, potentially chaotic situations. Adherence to these 'demands' generated the impression of efficiency and organisation. The requirement to staff a place irrespective of workload belied this impression.

It was also acknowledged by some of the midwives that different perceptions of time dominated different departments within the hospital. Outpatient clinic comprised of two, three-hour, sharp bursts of intense activity each day. These fitted relatively easily into the 'normal-daily-life' time of staff and attendees; acknowledgement of which was emphasised by the importance placed on punctuality, highlighted by the waiting-time audits. The inpatient wards attempted to establish a 'normal-daily-life', 'physiological time' 24 hour rhythm to the day, although this was moderated by ward routines, set meal times, rest times, and the regulated social contact of restricted visiting times. It was also sharply divided by the fast turnover of admissions and discharges; the accompanying administration created intense work pressure for staff even though of a relatively non-urgent nature.

Perceptions of time, and the way it was used proved very different on the delivery unit where the potential for conflict was most apparent. Providing a constant level of cover over the 24 hour period, patterning between night and day was appreciable only by a reduction in the number of staff; the use of bright lighting, particularly when busy, defied natural time, and unrestricted visiting for family members denied social time. However, physiological time cannot be over-ruled with the same ease and inter-professional conflicts of understanding and approach around this emerged as the 'active management' of obstetrics versus the 'waiting' of midwifery.

To some extent the timing of work was initiated and ordered by physiological time, the spontaneous onset of labour, although institutional time was superimposed with work created by elective caesarean sections and inductions of labour. However, it was rare for physiological time to be allowed to proceed without some element of control. Even physiological labours progressing "*efficiently*" and 'normally' were monitored by the clock; constant assessment of contractions in terms of frequency and duration, routine monitoring of the foetal heart, and regular assessments of progress helped tie the labour to chronological time. This was reinforced by a formal, supposedly research-based timeframe imposed on the process of labour (Rosser, 1994), an imposition that was both symbolised and actuated by the board in the delivery unit office (see chapter 4).

In the medical hegemony labour is not a safe time for mother or baby, and judicious intervention is indicated when there is a delay in the process. Although disputes over what constituted 'delay' were recognised, medical guidelines concerning appropriate timeframes were expected to be followed. Perceived delays in progress were quickly

noted and intervention recommended, - a system not just dependent on obstetrician's actions but, as previously noted, internalised and practised by senior midwives. However, conflicts arose between the junior doctors, focusing on time durations and milestones, and midwives, being more inclined to contextualise progress and wait longer. Some of the more experienced midwives talked about strategies used for subverting the time issue of the board, for example by not confirming full dilatation immediately suspected, thus effectively 'allowing' a longer second stage of labour before medical intervention was suggested. Many recognised how the use of the board controlled their work, how *"it sets the clock ticking"*.

Although birth is a normal, physiological process, valid concerns over maternal or foetal wellbeing are not uncommon, and swift action may be required to avoid serious problems. This encouraged an immediate time orientation and it was recognised that the pace of work on the unit may vary very quickly. As one midwife commented *"they work in hours down there"* referring to the wards *"whilst we work in minutes up here!"*

The peaks and troughs of work that are inherent in childbirth and the maternity service generate a clash between the rhythms of nature and those of the institution. At times staff had to remain on duty when there was little work to do; at other times the pressure of work was so relentless and staff so limited they quickly became exhausted and worried about safety levels becoming compromised. A seemingly constant fear of litigation served to increase the stress of these periods.

Partly to avoid such potentially dangerous peaks of work, and thus meet the requirements of the institution rather than the mother, the physiological timing of childbirth had become controlled with the use of dating scans to 'confirm' gestations to avoid potential problems with prematurity or postmaturity. Postmaturity was controlled by artificial induction of labour which, as with elective caesarean sections, was conducted at the 'convenience' of the hospital, not at the ideal gestation date but the closest when the unit has a space in the 'induction/theatre diary'.

The practice of such 'social' and highly controlling obstetric practice has been condemned, even by obstetricians (Savage, 1986; Wagner, 1997). However, the control of time during labour remained a predominate philosophy of the unit, posing a difficulty for the caseload midwives' developing respect for the physiological timing of labour.

Implications for midwives and midwifery

In providing a 24 hour service to a large number of women, the institution developed a momentum of its own. This seemed to have an inherent logic to it, which was then internalised and reinforced by the staff, as demonstrated in the clinic waiting time audits. In clinic time was very tightly scheduled, with the appointment system dictating a strict regulation to the flow of, and time allocated for, attendees. Disruptions to this system quickly caused long delays to develop. 'Waiting times' were a feature of the hospital quality control audit and staff were keen these were kept short. Such strict schedulisation was more likely to enhance the feeling of attending a cattle market, so commonly reported by antenatal mothers, than to improve the sense of quality of care received. However, the hospital midwives considered it important not to 'waste' women's time. Less consideration was shown to the midwives themselves.

In accepting employment, hospital midwives gave complete control over the timing of their work to their employers; inherent in this was a high element of control over their personal lives. Requests for particular duties were acceptable but not invariably granted; a few subverted the control by occasionally reporting sick when a requested day-off had not been granted. Acknowledging the Sapir-Whorf hypothesis (1985:1971) the accepted use of the term 'days off', rather than 'days on' linguistically reflected the domination 'institutional' time had over the midwives' personal time. Personal life was arranged around the needs of the hospital, often to the detriment of the individual - particularly those with young children, as witnessed in tensions generated over cover scheduled for school holidays, Christmas and New Year. The majority of midwives grumbled about personal difficulties incurred but appeared to accept this as "*part of the job*". Institutional time was accepted as the 'norm' for midwifery work.

Not only did the hospital midwives have very little influence over when they actually worked, whilst at work they had minimal control over the place and content of their working time. Meal-breaks were taken when allocated rather than chosen, to suit the workload situation; not infrequently on delivery unit, the relentless demands of crisis situations precluded meal, coffee, and even toilet breaks.

Although Hall (1959,1976) describes notions of 'modern' time as being scheduled and prioritised, within the hospital the midwives were frequently required to undertake many tasks at once, juggling the competing demands of a busy unit, incessant telephone rings, crying babies, concerned relatives and clinical emergencies. Not in ultimate

control of such situations the midwives were forced to be reactive rather than proactive and exhibited the disorientation identified by Hall (1969).

The tightly defined boundaries over the midwives' time generated a short-term focus that forced them into an immediate-task orientation, akin to a Taylor/Fordist division of labour (Godelier, 1988) where activities are broken down to their component parts and undertaken separately. Given the rotational nature of midwives' duties, continuity of carer was extremely limited, so gaining an understanding of the wider context of care, the mother's situation, became almost irrelevant. The philosophy of continuity of care was acknowledged, but so was the reality of conflicting advice given by colleagues.

Given the relatively short duty span in the context of longer care requirements, midwives were unlikely to complete care provision; they had to leave when it was time to go off duty rather than stay and complete the activity, such as assisting with a birth. Thus time, rather than completion of task, becomes the guiding focus of work. Yet this did not sit comfortably with the midwives. Many would 'stay behind', or miss meal breaks when a relief was available at an inappropriate time for the mother. Such practises were not encouraged; one midwife reported how a sister "*refused to allow*" her to stay on duty for the delivery of a mother she had been looking after. The reality of getting off duty at 10pm to return for 7.30am next day, the potential consequences of travelling through an inner city very late at night, particularly if reliant on public transport, and the certain knowledge that the extra time worked would not be remunerated or allowed for later, mitigated against such enthusiasm.

Hospital midwives were contracted to work 37.5 hours per week with a specific holiday entitlement. Payment for extra hours worked was not available except in exceptional circumstances; midwives were expected to 'take back' time when the unit was quiet by going off-duty early. However, the reality of understaffing and increasing workload meant they were rarely able to do this. Several senior midwives were 'owed' many hours, which they recognised they would never be compensated for. True commodotisation of their time had failed, ironically resulting in the institution 'stealing' an employee's time because they had focused on completing the activity for which they were employed rather than the time 'allowed'. This situation did not apply to community midwives who completed time-sheets to claim for work undertaken 'out-of-hours'.

The use of time within the maternity hospital took on symbolic valuation, and most importantly, developed a momentum that appeared unalterable. 'Time' became predominant, internalised and accepted as the normal, sensible way of 'doing things'. This held important implications for the way midwifery care was delivered and for the midwives as individuals. Such notions were challenged by caseload midwifery practice, as detailed below; a summary of the differences is presented as Table 20.

Table 20: A comparison of orientations towards, and use of, time for Midwives

Hospital Midwives	Caseload Midwives
Contracted for 37 1/2 hr work per week	Contracted for care of 40 women per year
Commoditised time – extra payment for 'unsociable hours'	Set extra allowance irrespective of time of day worked
Extra hours worked not paid	Not applicable
Clear divide between work & personal life	Work 'embedded' in personal life
Request particular days off	Negotiate free time with partner & group
Minimal flexibility to change duty	High level of flexibility
Work according to fixed duty-rota	Work when needed by women
Work period intensely busy or quiet. Unable to take advantage of quiet periods. No balance reported	'Long hauls' and quiet periods when minimal work. Can use to personal advantage. Reported to balance over time.
Work 'time' directed & controlled by hierarchy	Self-directed except where 'controlled' by labour and emergencies
Rota orientation – leave work when 'due off' – obstacles to staying	Activity orientation – finish work when activity completed
Current work has present orientation (task in hand)	Current work has future orientation (investment in future care provision)
Midwives' 'time' has a future orientation - immediate future work-time known	Midwives' 'time' has present orientation – immediate future work-time uncertain
Time is routinised, controlled, scheduled, de-personalised	Time is purposeful, flexible, uncertain, personalised

Time and caseload midwifery

Caseload practice required a radically different orientation towards time. The new style of practice challenged the notions previously developed within the hospital service, forcing midwives to redefine their concepts about time and its use. In 'giving back' to the midwives their control over their time, the maternity service implicitly acknowledged the control it exercised over those remaining in the conventional service, a feature that was apparently not overtly recognised.

The different orientation towards the use of the caseload midwives' time was structurally defined within their contract. They were employed to undertake specified activities rather than provide a set number of midwifery-care hours. Operationalisation of this requirement was at the discretion of the individual midwife and fixed additional payment, irrespective of actual 'unsocial' hours worked, facilitated their flexibility.

This strategy effectively de-commoditised the midwives' time. It also removed the pressure to complete an activity within a specific time, for example: before going 'off-duty'. By altering the focus of work from time to activity, midwives worked when and as they determined or were required. Thus they were able to use their time more effectively, no longer having to 'waste' it by going 'on-duty' when it was quiet and no work was actually required.

Without close managerial direction, the midwives now 'owned' their time and were able to deploy it as they considered appropriate, spending as long or as short a time as they considered appropriate to achieve the activity in hand. One midwife describing how she managed this situation noted: *"I tend to do less visits over a longer time"* (i.e. of longer duration). This presented them with enormous flexibility. Inevitably some variation in the way they structured their time developed. Some chose to start work early, others later in the day; some scheduled their routine work into a few long days whilst others planned for a more even spread.

Arranging cover at night and weekends was equally flexible. Some midwives preferred to remain available for their women, recognising the limited chance of being called, whilst others opted for alternating the night-cover with their midwifery partner, preferring the higher chance of being called one night with the certainty of not being disturbed the other. Such flexibility enabled each midwife to negotiate with their partner a pattern of working that best suited their lifestyle. Moreover, as their lives and commitments changed, such patterns were relatively easy to alter and adapt.

"You actually have to plan better when you are working shifts...I find I plan on a weekly basis... whereas before, when I was on the wards, you have to plan three weeks in advance because that's the way the rotas are done"

(i.pm04)

Unexpected events could be accommodated in a way they found impossible with fixed hospital rotas (e.g. by sharing and back-up within the group or by re-scheduling more routine activities). The midwives did not have total control over their time as they had to be available to respond to the needs of their women. Nevertheless, once they had developed their personal time management skills and learnt to advise, or "educate" their women appropriately they reported the interruptions at night were usually confined to labour and emergencies and proved to be minimal.

"At night? It's not very often. I would say on average a month I would get three. You can't put (a number on it) ... Or you may be contacted three times in one night!"

(i.pm06)

Such reporting was verified in a study of their work diaries (McCourt, 1998).

Knowing the women who contacted them enabled the midwives to respond appropriately, not necessarily having to visit but give advice or make an appointment. This contrasted with their colleagues in the conventional services where calls from 'unknown' women had to be treated with care; with no prior knowledge of particular situations, most calls necessitated the woman being asked to come into hospital or visited at home by the community midwives.

These two features, knowing the women and infrequent night calls, were symbiotic; in relating to the person of their caseload midwife rather than the role, women were reported as not wanting to disturb her unless it was urgent. This appears to be one of the most misunderstood features of caseload practice. In considering this model of care both midwives and doctors related to the term 'on call' as in their own experience where they were invariably disturbed. Alternative models, where they were 'available' yet rarely called, appeared incomprehensible.

Nevertheless, the onset of labour and other emergencies would prove disruptive to the midwives at times. Scheduled work required reorganisation and, if called at the end of a day's work, physical stamina for the "long haul" as the midwives termed it, was needed. However, they said these busy period were balanced by the quiet ones when they could relax at home or with friends.

Working with women's time

As their time was not tightly defined or structured, and largely within their control, the caseload midwives were able to work within women's individual time constraints. They reported undertaking early morning or, occasionally, evening visits to suit the convenience of the couple they were seeing; this was a situation the Community Midwives reported being unable to undertake as they could not be paid for such 'overtime' visits. Two community midwives undertook such work but they were the exception rather than the rule, and not paid for such 'dedication' (Kirkham, 1999).

Caseload midwives also appeared more willing to work within women's physiological time frame, perhaps because of their greater knowledge and understanding of personal situations, and the greater flexibility they experienced personally. With minimal previous experience of home births, the midwives reported finding that deliveries at home had a very different quality. They became more aware of the physiological rhythms of labour, which, away from the constraints of hospital-dominated time were found to be very different from that they had considered 'normal' (Flint, 1986). The midwives considered they learnt this by having to advise women during the early stages of labour and then caring for them through the active phase, rather than providing an eight-hour period of care isolated from the wider context of labour.

With experience the midwives undertook an increasing amount of care during the first stage of labour at home, moving into hospital for birth when appropriate. Towards the end of the study they talked about making the decision for place of delivery during labour itself, when it was considered to be most appropriate, although this was not then accepted procedure.

The caseload midwives tried to subvert the hospital-time imposed on labour by a strategic use of 'the board' in delivery unit; as previously noted, this refusal to comply with accepted procedure generated tension on the unit. Also, with a greater understanding of individual situations, they became more flexible in applying the unit's guidelines and protocols concerning labour. In describing a difficult delivery involving a long second stage, one caseload midwife explained that, because she was aware that the mother was unsure of the parentage of her child and was fearful of her baby's colour at delivery, she considered the delay was due to the mother psychologically holding back. In this situation the midwife considered that, while indications of the baby's

wellbeing were satisfactory, support and understanding were more appropriate than speeding up the labour with hormonal stimulation.

In such situations, providing they could justify their careplan to the obstetrician's satisfaction, if questioned, the midwives' decisions were usually respected. Where they were not, usually by a less confident registrar who did not know the caseload midwife and imposed intervention, the midwives reported later proactively following up such unsatisfactory management with the delivery unit consultant. In becoming confident to question medical behaviour in this way, the midwives had to be very sure of their own management. This also reflected a growing confidence with their body of midwifery knowledge.

Implications for caseload midwives

Such flexibility held distinct advantages for midwifery practice and mothers, as described. Nevertheless, personal adaptation by the midwife was not necessarily easy or successful. As highlighted in chapter 6, it took many months to settle into working this way and the most fundamental adaptation, although not overtly recognised, was likely to be to the different notions and uses of time.

Their lives were no longer clearly compartmentalised into the scheduled trichotomy of work:social/domestic:sleep of Hall's monochronic time (1969) but work became embedded in the general passage of their lives in much the way Bourdieu (1963) described for the Algerian peasant or Bohannan (1967) the Nigerian Tiv. This lack of compartmentalisation of time may also be considered a feature of post-modernity, with the movement to more flexible patterns of working, in both time and space, indicated by the development of 'flexihours' and home-offices. It is certainly a feature of the lives of a level of those in more autonomous positions, such as senior corporate managers and senior professionals (Giddens, 1987).

This way of using time had a direct impact on the way the midwives viewed their lives; it also held a certain ambiguity. Long-term planning was important for negotiating holiday time, and a balance to the caseload; it also incorporated the essence of 'investment' in their work discussed previously. However short-term planning was less assured, forcing a more 'present' orientation. Nevertheless, although they would know due dates for delivery and might have a sense of impending labours, they never knew when they would be called. Even when quiet, their busier colleagues might require

support. The midwives recognised it balanced out, that periods of intense activity would be followed by quiet spells. However, their appreciation of the quiet times was probably more retrospective than immediate, the exact duration of the quiet period only being defined once it had passed.

On a day-to-day basis the development of a forward orientation was limited as anything planned during 'available' periods could be disrupted by unexpected labours or emergencies. The ability to plan in certainty and enjoy the anticipation of particular social activities was determined by the support provided by their partners or group, and defined by whatever strategies for cover they had negotiated.

The midwives mobile phones became both the symbol and reality of this embedded work, freeing them to go wherever they wanted, within reason or social dictates for the use of mobile phones, when officially 'available' but also interrupting such activities with the demands of their caseload. This extended into all aspects of their lives, with coitus interruptus laughingly being described by some as a new form of contraception.

Once they had become used to it, for some midwives the phone was reported as giving them freedom and 'helping them make the job work for them'

"I take the phone where ever I go and it doesn't really affect me."

(i.pm05)

Another equated it to her "right arm".

To others it gave confidence; they could contact women about whom they were concerned, but more importantly, the women could contact them, a situation which helped some midwives to relax. Nevertheless, some midwives appeared unable to completely relax, and reported great joy in handing in their phone when leaving:

"I couldn't wait to give back the phone once I knew I was leaving. I felt so tied. Tied by the phone you know. If you go out of the city for the weekend you can only go so far (when 'available'). You have to be reached by the phone. That takes its toll."

(i.PM07.2)

Adaptation to this 'embedded' more traditional use of time was dependent on both personal characteristics and personal situation. It clearly suited those with a flexible and relaxed attitude towards work and life in general, proving more problematic to those who enjoyed living very structured lives. This different approach to 'work time' also made different physical demands on the midwives.

Acknowledging the times when they would be called to a labour after a working all day, these “*long hauls*” as they termed them necessitated a type of physical endurance that differed from the extremely intense, yet relatively short (8-9 hours) term endurance demanded by busy shift duties. One of the midwives who decided this style of practice was not for her commented that she had found out she was a twelve-hour person, after that she could not cope without sleep. Other midwives preferred the less stressful though longer days to their experiences in hospital. In comparing her experience with both systems, one midwife commented that she would rather be “*knackered than demented!*”, a comment illustrative of the difference between the physical tiredness experienced in caseload practice and the mental and physical exhaustion experienced in the hospital service.

Considering the problem times, a midwife highlighted the difference between short-term not coping and long-term not coping, suggesting there was plenty of the former in caseload practice but implying the latter belonged to the hospital, a comment holding resonance of Sandall’s (1999) conclusions concerning burnout amongst midwives.

“It’s not a continuous thing that goes on for months or weeks on end – it’s only a few days. But it’s difficult and there is really not anyone you can go and say... If we do complain it’s ultimately thrown back in your face (by managers) as “You don’t manage time effectively””

(i.pm06)

The requirement to be able to manage their time effectively was appreciated by the implementation team but was not identified by the selected prospective caseload practitioners when training needs were being established. However, as one later noted, until they had the hooks to hang it on, such training would have been pointless. Once they had some experience of the implications of carrying a caseload, time management training was welcomed.

Time Clashes

Many of the difficulties the midwives experienced as caseload practitioners related to clashes experienced at the interface between their ‘traditional’ / ‘post-modern’ concepts and uses of time and others’ ‘institutional’ or ‘modern’ notions. These occurred in their domestic situation, with some of their clients, and when working in the hospital.

Domestic

'Clashes' that developed in the domestic domain were highly individual, and depended on particular circumstances. Undertaking domestic chores was considered easier by some, although others reported their social partners undertook more of the domestic duties such as cooking. Being called when socialising with friends was difficult for some, whilst others said they experienced minimal problems in negotiating such situations; most midwives commented on not being able to drink alcohol when 'available', but reported adapting to this.

Individuals who valued highly an extremely active social life reported no problems providing their work-partner agreed to a determined and reciprocal cover arrangement, such as alternate nights and weekends. Tensions emerged when such arrangements proved difficult, as when one partner wanted to cover for her personal caseload most of the time, offering rarer and specific cover for her partner, whilst the other preferred a more routine arrangement of alternate nights and weekends. Such clashes were best resolved by changing to work with more like-minded partners.

Midwives with stable and established live-in relationships appeared to experience less domestic tension than those with new or changing relationships. Those whose partners who worked set 'office' hours reported seeing more of them as they were more likely to be at home in the evening.

"my husband works 9-5 hours but I find it works to my advantage, I have more free time and am usually at home for supper rather than out 2-3 times a week"
(fg.nm.pm31'97)

The midwives contrasted this with hospital work where, with evening and night shifts, couples met as "*ships that pass in the night*", particularly if the partner also worked shift duties. The greatest problems occurred when couples lived apart, particularly if separated by any distance. Tensions arose when visits together were interrupted by calls to work.

During the data collection period only a few midwives had young children to care for. However, from the limited data available it became clear that any problems resulting from the midwives flexible work patterns clashing with more structured childcare arrangements were an individual rather than inevitable feature of the model. Two midwives reported finding childcare when working with a caseload considerably easier than with the shift pattern of work, but they acknowledged they benefited from flexible

and supportive domestic arrangements such as the close proximity of supportive 'grandparents'. Others experienced greater difficulty, and reported feeling guilty when relying on friends to assist.

This situation exemplifies one of the difficulties of using time in a more traditional way within a society that is structured and dominated by scheduled industrial time. In traditional societies childcare is commonly conceived of as the responsibility of the wider family, not just the mother. Where specialised childcare arrangements have to be adopted the uncertain nature of caseload practice can result in high fees or high levels of stress. One midwife reported leaving caseload practice when her childcare arrangements proved so difficult that she realised she was providing better care for her clients than her family; the situation proved untenable. However, she considered she could not, and did not, return to hospital clinical practice.

Client

Although the reports were few, it became apparent that some clients experienced difficulty with the flexibility that was an integral part of the midwives' use of time. Living within a structured, scheduled time frame, their highly organised lives were disrupted when planned visits had to be cancelled at short notice (for example, for the midwife to attend another mother's labour). One husband wished to lodge a formal complaint to the Trust, explaining how angry he had become when, having cleared time from his city occupation in order to meet the midwife, this visit was postponed at the last minute. He clearly considered his time had been 'stolen' by the midwife's inefficiency. In industrialised countries, punctuality is indicative of efficiency, although elsewhere aspects relating to respect, status or power are more heavily stressed (Hall, 1959:1976). Such clashes, unless recognised and tactfully handled, irritated clients who then interpreted the midwife's behaviour as disorganised or unreliable.

Mothers who did not have a telephone presented a particular problem. Serving a relatively deprived community in some patches with an increasing refugee population, some mothers lacked telephone access. Changing their appointments proved difficult, although usually a male relative would have a mobile phone; communication was made that way but was not considered reliable.

Hospital

More serious difficulties developed when the midwives interfaced with the hospital service, where institutional time predominated. Problems were generated both in the way activities were undertaken and the negative stereotyping which developed from misunderstandings, a situation well recognised in cross-cultural misunderstanding relating to time (Hall, 1956, 1969, 1979; Carroll, 1990; Griffith, 1999).

The interface in outpatient clinic was reported as a constant problem by both groups of staff. Clinic was managed on a tight schedule and waiting time audits were commonplace. Therefore the hospital midwives reacted sharply when caseload midwives did not appear as arranged, leaving their clients waiting for what was deemed 'unacceptable' periods (although the evaluation indicated 'caseload mothers' waited for shorter times overall). They also complained of the caseload midwives spending "*too long*" with women and so "*blocking*" rooms. As there were 20 caseload midwives, and several might have clinic appointments at similar times, undoubtedly they caused serious disruption to the smooth running of clinic, a situation which various strategies were adopted to help minimise.

In the more relaxed atmosphere of the inpatient wards, the hospital midwives still complained that the caseload midwives were inefficient and disorganised; they appeared at irregular times of the day and could not be relied upon to attend when planned. Hospital midwives initially had difficulty defining the idea that caseload midwives would provide 'all care'; many chose to interpret it literally and frequently both mothers and caseload midwives reported 'essential' care being delayed until the caseload midwife visited. In such situations the caseload midwives were reported as being lazy, poor timekeepers, and totally disorganised, descriptions not infrequently applied to the same hospital midwives by the caseload practitioners. Both students and junior midwives noted how some hospital midwives phoned the caseload midwife for non-emergency queries at any time of day or even night. The perception acted on was that as hospital midwives covered the hospital 24hour a day so did the caseload midwives, therefore it was appropriate to contact them at 3am for a minor query.

On delivery unit, where time took on a shorter, more concentrated dimension, the relaxed attitude and flexibility of the caseload midwives proved particularly irritating if the unit was busy as described in Box.17:

Box 17

8.30am

The unit is frenetically busy, staffing is difficult and there are a number of emergencies. Access to the telephone is constantly required.

One of the two phones is being used by a caseload practitioner to reschedule her day's work, having brought in a lady in labour. She is unaware of the intense irritation she is generating by her relaxed and humorous, although totally work-orientated, conversation. Her use of the phone lasted about ten minutes.

Nothing is said but strong 'looks' are exchanged between medical and midwifery staff.

Note: The caseload midwife's character was visually assassinated!

A clear example of a 'time-clash'.

Source: DU. observation study no.10 1997

A second area of tension arose between the shorter periods of duty and longer duration of caring for a woman throughout labour, where caseload midwives received little help from hospital staff. Particularly in the early days, the hospital midwives considered it inappropriate to offer help. However, they did not fully appreciate how long a particular caseload midwife had been on the unit, nor their previous workload prior to attending the labour. The attitude of non-support may have been fuelled by the caseload midwives initial reluctance to update the board on the unit, recognising they did not wish to "*set the clock ticking*" and be dominated by medical time and interference unless requested. As a result, the sisters-in-charge of the unit were then identified by the obstetricians as not knowing what was happening. As a response some of the sisters appeared to marginalise the caseload practitioners. This situation diminished over time but unsupportive behaviour was still noted from a few hospital midwives at the end of the data collection period:

"some people are loath to do even little things for you, whilst others can be so nice, and even when it is heaving will ask 'are you alright?'"

(fg.om.'97)

Time and radical change

Frankenberg (1992:16) suggested that "*Revolutionary changes in health services, ... require that time itself is turned upside down*", commenting how, in '*Das Capital*' Marx exhorted workers to take charge of their own time. He also noted how a more egalitarian form of health care, defining carers and cared for as equal participants in the

healing process would neither need nor be able to treat the time of others as within its control.

Practising with a caseload involved a radical change for midwives, not least in the way time was conceived and controlled; this held fundamental implications for the midwives' work and lifestyle. The more reciprocal relationships established with mothers included a mutual respect for each other's time and, with a less controlled patterning of their own time, midwives gained a greater appreciation of the physiological timing of labour.

Such adaptations are not necessarily compatible with an individual's personal characteristics, preferences or domestic situation, and for this reason caseload practice must not be considered as the only way to practice midwifery. Diversity in models of practice is essential to enable midwives to move between forms of practice that suit their changing personal situations. Nevertheless, this study indicated that many midwives might find the style of individual caseload practice more acceptable than the confines of hospital practice and the institutional domination of their time.

Frankenberg (1992) remained pessimistic as to the viability of the change he had outlined, considering such relinquishment of power to be idealistic. Somewhat appositely he used the metaphor of childbirth when presenting this idea, suggesting:

Historical changes, like women in labour, still need midwives, even if for both they can most usefully be chosen from among their friends."

(Frankenberg, 1992:18)

The nature of caseload midwifery practice appeared to support his views on revolution and egalitarian health care. The fact that it had been successfully implemented, as indicated in this study although only as a small scheme, undermines his pessimism but concurs with his valuation of 'friends', albeit it 'professional-friends.

Chapter 11

SUSTAINABILITY OF CASELOAD MIDWIFERY

Although caseload practice clearly increased these midwives' sense of job satisfaction, to the degree that they expressed dismay at the prospect of returning to more conventional forms of practice, it is necessary to consider whether the model is sustainable in the longer term. In particular it is important to identify issues that are specific to this local situation and those more applicable to the model in general.

Consideration will first be given to the midwives' view of the service and the reasons why some left. Then, following a reflection on the concerns presented in studies of other 'continuity' schemes, those features that appeared to support and sustain this model of practice will be summarised.

Caseload midwives' views of the model

In assessing whether caseload practice was a sustainable model or not, the views of all midwives who had worked in it were sought again at the end of the data collection period. A questionnaire (appendix 2) was distributed to past and current midwives in which they were invited to identify the strengths and weaknesses of the service in general, and three positive and three negative aspects they had experienced working in it. Of the thirty five questionnaires sent out, thirty were returned. Their responses are summarised in Tables 21 and 22 respectively.

The midwives' comments on the service indicate it held positive benefits to both mothers and midwives. The weaknesses identified related to both local issues, and others common to the wider context of midwifery work; however, ongoing practical and psychological support, or lack of this, was identified as a key feature of this model

Table 21: Perceived strengths and weaknesses of the current service

<u>Positive Features</u>	
For women:	Achieved individualised, quality care for women and their families Provided continuity of care and carer
For midwives:	Gave fulfilment and job satisfaction Developed all skills Provided good peer support Gave valuable experience for students
For service:	Achieved goals of Changing Childbirth Co-ordinated multidisciplinary care meeting client needs and preventing duplication Motivated midwives
<u>Negative Features</u>	
Lack of support: limited resources	
Poor senior management support	
Relations (tensions) with hospital staff	
Poor cover for sick-leave etc	
Service was geographically limited and seen as elitist (expansion desired)	
Lack of child care facilities for midwives	
Lack of promotion opportunities	
Practical issues (various cited)	
Service delivery over 2 hospital sites	

1997 Questionnaire response nos. 30/35

Table 22: Summary of midwives' views about working in the 1-1 service:
(positive and negative points identified)

<u>Positive Points</u>	<u>Negative Points</u>
<p><u>Current midwives</u> nos. 19 + 3 maternity leave</p> <ul style="list-style-type: none"> Relationship with women & their families Autonomy of practice – working independently, organising own work Professional development – practising in all areas; obtaining feedback, opportunity to reflect on practice Continuity – both within pregnancy and between pregnancies Group/peer Support & shared philosophy Flexibility of working hours Job Satisfaction Variety – clinically & cultural mix of clientele Working in community 'Being a person' <p><u>Leavers</u> nos.8</p> <ul style="list-style-type: none"> Standard and type of care provision: <ul style="list-style-type: none"> able to offer high standard holistic care, professional fulfilment Relationship with colleagues Relationship with women Job satisfaction 	<ul style="list-style-type: none"> Attitudes of hospital staff: midwifery, medical & management On call Uncertainty about future of project Demanding women Long hours Conditions of service (eg. pay & holiday, smaller caseload; problems with lease cars & phone bills) Inadequate staff cover / shortages Colleague partnership problems Working over 2 hospital sites <ul style="list-style-type: none"> Poor Support – poor backup when sickness, very busy, delays in filling vacancies, Interpersonal conflicts, Hospital interface (attitudes of staff) Intrusion of work into personal space & time

1997 Questionnaire response nos. 30/35

Their views about working this way echo the analysis of interview data concerning the meaning of caseload practice for midwives. They particularly valued the professional development and relationships they were able to form with the women and their colleagues; both contributed towards increased job satisfaction. However, their views on difficulties experienced reflected both the demands of the job and management issues related to the local situation, and complaints of midwives more generally concerning pay and conditions of work.

‘Turnover’ Rate

The attrition rate of midwives in this context - inner city teaching hospitals in an area of high mobility and housing costs - were generally high. In line with national staffing problems, the ‘turnover’ rate and unfilled vacancies in this trust as a whole increased during this period, reaching very high levels during 1997. Routinely collected data showed no clear differences in midwifery turnover between the pilot and conventional services. The turnover was higher for the project in 1995, the final year of the ‘pilot’, when seven midwives left during a four-month period of uncertainty about renewal of their contracts, whilst in subsequent years it was lower than for all midwives in this Trust.

From the project, fifteen midwives left during the research period November 1993 - August 1997, 12 of the original and three of the midwives appointed subsequently.

Reasons for leaving

It is possible to distinguish differences between two separate groups of midwives working in the project. The first group had to act as change agents, carving out a midwifery service from within a predominantly medical dominated, medical model of childbirth, whilst the second group needed to refine the service delivery. Quite different demands were made on each group. This in turn may have had an affect on attrition. In this study the analysis of the reasons midwives left focused on data from the original midwives as the subsequent group of leavers were only three in number and had left for particular reasons, as indicated:

- * one left after three months, having been awarded a fully funded place, previously applied for, for Health Visitor training; this person was not included in any data collection because of their short duration in the project.

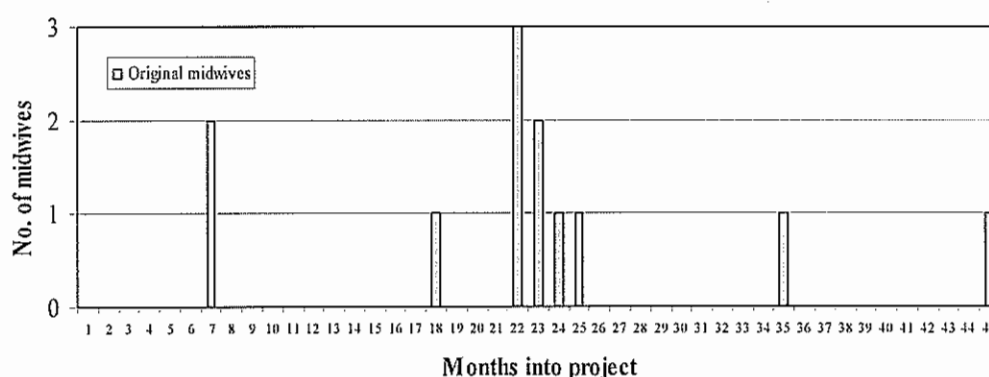
- * one person employed on a temporary contract covering maternity leave, left for a senior position elsewhere but returned, on a lower grade, when a permanent caseload contract became available.
- * one left due to circumstances rather than choice with the break-up of a job-share arrangement. This person transferred back into the hospital service.

Data from the original midwives offers an understanding about the demands made on them during the early stages, highlighting some of the weaknesses and lessons to be learnt from this implementation.

Of the original midwives who left, one remained with the Trust working in a non-clinical position; four remained in clinical midwifery in other Trusts, three in higher graded positions; two undertook full-time studies in midwifery, and five left to travel overseas.

The motivation to leave may be a result of several factors that interact with each other rather than one particular issue, so it is important to recognise the complexity of the situation. Analysis of when midwives left, as presented in Table 23, highlighted that two midwives left after seven months, during the transition period which involved a very 'steep learning curve' and before they had learned to 'make the job work for them'. They clearly felt unsuited to caseload practice. Also, seven midwives left during the period August '95 to December '95. This was a time of considerable uncertainty and change in the project and its management, with the midwives considering they were receiving little assurance from management concerning the future of what was initially a two year project. Motivation to move was clearly enhanced by a sense of poor job security and feeling undervalued.

Table 23: Number of 'original' midwives leaving by month of project



An analysis of both exit interviews and questionnaire responses identified several themes which could be grouped into four key areas: personal circumstances, personal characteristics, pilot scheme characteristics, organisational issues.

Personal circumstances

Work was undertaken within the context of particular domestic arrangements and a social life. As discussed in the chapter concerning time, in caseload midwifery these elements were symbiotic rather than exclusive. Thus many of the midwives left when their personal circumstances changed. The movement of a partner (3) or development of a family proved particular catalysts although such changes did not inevitably precipitate a move. The midwives discussed how a forthcoming change had caused them to re-evaluate their situation; resignation was not automatic but a carefully considered preferred option. One midwife, whose partner's work moved overseas, considered staying and periodically visiting him but rejected this as not being financially viable; another clearly wanted to continue with caseload practice but was torn when her partner moved away. Two years later she noted in her questionnaire:

“If I had remained single I would probably still be there now as I really enjoyed it”.

(qr.pm22)

Initially, the data suggested that caseload midwifery was incompatible with a young family, as the three midwives with young children all left (2 original, 1 subsequent midwife). However, the analysis indicated that the situation was dependent on personal circumstance and support mechanisms. One midwife with a young child, who was job sharing, resigned when she found the uncertainty of being called out and the requirement for constant negotiation and re-negotiation childcare arrangements exhausting and detrimental to her family life. In the two other situations, the midwives with young children considered caseload practice to be compatible with family life; one who had children when working in the hospital service reported finding it easier in caseload practice. Both had excellent childcare arrangements and support and valued the flexibility caseload practice offered them. Nevertheless, they were both ‘forced’ to resign when their situations changed; one moved out of the area, away from supportive relatives, and the other's job-share arrangement collapsed.

Supportive and flexible childcare arrangements proved to be essential features for mothers carrying a caseload. Helpful factors included the presence of a wider, supportive family

network and partner's work commitments that were flexible and family friendly.

Compounding factors included a domestic partnership isolated from close family support or a strong network of friends, or a partner whose work commitments were rigid in structure (e.g. duty rota) or particularly demanding.

Personal characteristics

Caseload midwifery practice was not suited to everyone because it demanded a radically different attitude towards work, and in particular the use of time and a blurring of the work:leisure dichotomy. Several midwives who delayed joining the project reported their initial concerns about the perceived requirement to be 'constantly available' for mothers. Several appreciated the opportunity to "test out" the practice by undertaking maternity leave cover; all these midwives subsequently applied for and were given permanent positions within the service. However, with no previous experience to inform the twenty original midwives, and no opportunity to 'test it out', invariably some individuals were less able to adjust to the different lifestyle that the unpredictability of the work dictated.

One midwife noted how she did not possess the physical stamina occasionally demanded by the "long hauls" when called out after a day's work and that:

I've discovered that I'm a twelve-hour person and after twelve constant hours of working I rapidly go downhill and become very irritable, short-tempered and feel stretched to the limit.

(i.pm01.2)

With experience, the midwives reported the 'long hauls' became less frequent, and in developing strategies of coping they became more manageable. Such strategies included: keeping in touch with women at home during early labour but not staying with them if not needed, appropriately using students to stay with women for periods in early labour whilst they complete other work or got some rest, and calling colleagues when getting too tired. Nevertheless, the midwife quoted found herself unable to relax when 'available' and clearly preferred a more defined working day.

Another midwife recognised she had made a mistake in her approach to her work but felt unable to change her practice. Locked into a particular, self-imposed, way of practising (independently and aiming for 100% continuity of care) which she later considered detrimental to herself and her clients, she was leaving in order to change. Her move was not a rejection of the style of service but an acknowledgement of the importance of defining the boundaries correctly and not encouraging people to depend on her

inappropriately. A third midwife, leaving after two years, stated that she had enjoyed the work and considered she had done a good job but that the style of practice was not suited to her personal, highly social, lifestyle.

Features of a pilot scheme

It has been suggested that the project proved successful because it attracted highly motivated midwives who were unique in some way. The data suggested any difference was attitudinal, attracting those who sought a challenge. Personal characteristics that are demanded by and honed during a difficult implementation are not so important during the subsequent development of the service. It is possible that individuals who rose to and enjoyed the original challenge felt less 'stretched', and even became bored, as the service was established. They left to seek further challenges elsewhere; one commented that caseload practice was *"not as stimulating to me as it was"* (i.pm07.2), another left to

"progress further...to learn more about research....to consolidate my experience in an academic way. ... I'll be upset to leave, but I'm moving on".

(i.pm05.2)

A third, although considering that *"working this way is very, very rewarding. This is midwifery"*, was leaving to seek further challenges elsewhere:

"I want a major change in my life at the moment. I'm leaving my boyfriend, I'm leaving my job, I'm leaving my family, I'm leaving my friends. And it's going to bring me challenge."

(i.pm06.2)

Finding fulfilment at work does not necessarily stop individuals leaving to seek fulfilment in other areas of their lives.

Organisational issues

It was clear that the implementation period carried stresses that the midwives found particularly tiring. The following comments, taken from one exit interview, illustrates some of the pressures involved in their working environment during the project's earlier days, a period they called *"the initial 'proving' period"*:

" (It was) *organised chaos*"
"*coping with medical and midwifery colleagues' anxieties as well as your own*"
"*everyday there is a battle about something*"
"*there was always something you had to be confrontational about*"

(i.pm01)

The impression of being constantly involved in a battle was reflected in discussions with other caseload midwives, as was a strong sense of the amount of energy they had put into the project. The energies demanded by any implementation are in excess of 'normal' working conditions. With this project, the requirement to meet the demands of the service and the expectations of the implementation team and midwifery profession, in the knowledge you were being carefully scrutinised by an extensive evaluation, intensified the situation. The midwives were also testing different ways of working, rejecting those that proved problematic and trying new ideas that might work for them; compounded with colleague movement and partnership changes the drain on their energy levels was high.

The initial management of the project had combined good support with a facilitative approach. However, once the project was incorporated within the mainstream service the midwives felt they had lost managers to whom they could turn for support. Continuing indecision about the future of the practice added to their general sense of uncertainty and of being undervalued.

"We are still 20, we haven't even achieved the 24 originally aimed at: I don't know about rolling it out, we cannot even cover all of (the areas designated). We have never had a clear answer - that is the reason a lot of girls left. We have lost a lot of brilliant girls".

(fg.om.'97)

The remaining midwives felt strongly that some of their colleagues might not have left had the service been more clearly supported by senior management within the Trust. The support desired was identified as recognition, both verbal and financial, for a job well done, as well as assistance with problems the midwives were unable to resolve; for example: ensuring they were not left covering two caseloads by providing cover arrangement. The importance of appropriate support has been identified as a major theme of the research, having been raised by all the midwives at different times and in different contexts. In responding to the "*Why did you go*" section in the questionnaire, two years after leaving one midwife wrote:

"Lack of support and teamwork from partner. Lack of support from management re above. Working on my own. When management (was) made aware, no support (was) given and (I was) basically told to get on with it."

(qr.pm07)

In discussing her reasons for leaving, one midwife highlighted support as the fundamental requirement for this style of practice. When asked if this style of working was feasible, she responded:

"YES (adamantly) Yes it is, if you have got the backup. If there is properly organised back up to cover sick leave etc".

(i.m05.2)

These factors are not intrinsic to caseload midwifery practice, but if they are present and are not recognised and adequately addressed they may prove to be fundamental in motivating midwives to resign.

Caseload midwifery and alternative models

It is helpful to consider the sustainability of caseload midwifery in relation to the issues raised by the evaluations and commentaries of a number of midwifery schemes introduced since the 1980s.

As noted in the background chapter, a wide variety of Team Midwifery schemes were implemented prior to the Winterton and Cumberlege reports, aiming to enhance the midwife's role and provide a less fragmented service for mothers (Wraight *et al*, 1993). These varied in size, they were located in hospital or community (very few covered both), and they aimed for very different degrees of continuity over the antenatal, intrapartum and postnatal periods. Although most were not evaluated, problems with these schemes became apparent. Midwives reported achieving higher levels of job satisfaction and valued a wider use of all their skills. However the need for increased flexibility was problematic and the accommodation of part-time midwives awkward (Stock and Wraight 1993). The fundamental difficulty was in creating an acceptable balance between providing continuity for women and midwives having time off.

The debate concerning definitions of 'continuity', as continuity of 'carer', 'caring' or 'care' (Lee 1997) stemmed from this period. Uncertainty over the central issue questioned whether it was more important for women to see the same person or to avoid conflicting care and advice being given. Several writers suggested that the latter could

be achieved through the adoption of standard protocols for working and similar attitudes and philosophies agreed through the formation of mission statements (King's Fund, 1993; Lee, 1997).

A variety of organisational changes were introduced to address the issue. Individualised care plans, 'patient allocation', DOMINO schemes, nursing/midwifery process model, and team midwifery were all identified in a study of maternity services' responses to improving continuity of care in Scotland (Murphy-Black, 1992; 1993). Team midwifery was considered the only change that successfully achieved both continuity of carer and care (Murphy Black 1993). Similar changes were underway in England.

The difficulty in balancing the needs of women with those of midwives remained the fundamental problem of changes introduced in response to the government directive (NHSME EL(94)9). The findings of the evaluations of the newer schemes mirrored those identified by Stock and Wraight (1993) and raised a number of questions concerning the viability of continuity schemes. In their review of the evidence, Green *et al* (1998) identified three key questions:

- How important is continuity for women?
- What does 'knowing' really mean and what effect does this have on outcomes of care?
- What are the costs to midwives of providing continuity of care?

From the preceding chapters it is clear that this study is able to inform aspects of these questions and offer an understanding from the perspective of caseload midwifery practice as experienced in one particular situation. It is not the intention to suggest that a definitive answer can be provided, clearly the subject is far more complex than one study can address, nor to claim that caseload practice is superior to other models. Each midwifery service is unique, designed for specific populations and situations. The aim is to use the findings of this study to address the questions raised by the other studies, in the context of the sustainability of this and other such models of midwifery practice.

In approaching these issues, two fundamental differences between this study of caseload practice and the other studies need to be acknowledged. One concerns the nature of pilot studies, the other the philosophy of midwifery.

Pilot study or honed service

One of the difficulties in assessing the findings from the evaluation of pilot schemes is their short duration. The findings of this study suggest that the short time span applicable to most evaluations provided a questionable basis from which to draw sound conclusions concerning viability.

Stock and Wraight (1993) indicated that any new scheme should have a long planning period, approximately 18 months, which involved wide consultation with all parties. This recommendation has not been heeded in most schemes (Green *et al*, 1998).

However, as Allen *et al* (1997) succinctly summarised,

“Demonstration projects set up with limited funding for limited time, little lead-in time, staff who had not worked together before, new methods of management and practice, high expectations and little experience of managing change can expect to experience multiple problems.”

(1997:227)

Despite this recognition, the indications are that some pilot projects have been closed down as a result of such problems being highlighted (Hart *et al*, 1999).

This longer-term study indicated that many of the so-called ‘problems’ of continuity schemes are likely to become resolved over time. However, such resolution is not accommodated in pilot schemes nor acknowledged in short-term evaluations, none of which appeared to last longer than 18 months. One might also argue resolution is not automatic and will depend on the way change is handled and how organisations do or do not learn from experience. From this study it was clear that:

- a) The initial ‘teething problems’ associated with the changes were resolved, as the strange became familiar and accommodations were made. However, this did not happen automatically and required an appropriate framework within which changes could be negotiated.
- b) The adaptations demanded of the midwives in changing their style of practice took time; the ‘transition period’ for the ‘original’ midwives’ was estimated as lasting ten months.
- c) ‘Problems’ found in other pilot schemes were identified in caseload practice and they required specific acknowledgement and strategies developed to avoid or overcome them. For example:

- Allen *et al* (1997) noted difficulties with group relationships became so bad that one group called in an outside counsellor to help them resolve their differences. In this caseload practice study the role played by the group, in terms of support and practice development, was highlighted as crucial. Poor inter-group relationships proved disruptive and destructive. Good relationships could not be assumed but had to be worked at; occasionally the input from a supportive and empathetic manager was required. Such 'group relationship' skills had not been honed in the conventional service where strategies of avoidance rather than resolution were more commonly exercised. These skills developed with experience.
- Both Green *et al* (1998) and Allen *et al* (1997) questioned the cost to the midwives personal lives, highlighting problems with the formation of dependency relationships with their women and the potential danger of working when fatigued. These were also identified as concerns by the caseload practitioners, although proved to be potential rather than actual problems. However, they highlighted the importance of each midwife clearly defining their boundaries, and accepting responsibility for when not to work, as much as when to work. 'Appropriate' guidelines, and managerial and peer support that draws on such experience, were found important in helping midwives develop appropriate boundaries and approaches.
- Allen *et al* (1997) suggested that "*potential resource implications are very high if midwives provide 24 hours on-call cover for their women*" (p.234). They noted this had been resolved in one situation, the scheme analysed here, by a negotiated salary enhancement that was considered an important modification. The findings presented here support that statement. Issues relating to use of time and control of time were fundamental to caseload practice (see chapter 10). The removal of the constraints of an economic valuation placed on time, where budget limitations for overtime and unsocial hours payments impose particular working hours, facilitated midwives' flexibility over when they provided care.

Allen *et al* (1997) also raised the issue that high levels of consumer satisfaction may be associated with groups of dedicated and committed midwives rather than a feature of a particular model of care. They should not be assumed to indicate the model as the ingredient of success. Although an important point, it was a reflection on newly implemented schemes rather than established services. This raises three issues:

- 1) Although such schemes may attract highly motivated personnel, their enthusiasm is likely to be mitigated by the stresses of implementation and learning the job. The findings of this study suggest that it took at least ten months for the midwives to settle into the new style of work and possibly considerably longer to become truly proficient at working this way.
- 2) The initial midwives acted as 'change agents', and were likely to move on. A study of the subsequent practitioners offers a sounder basis from which to draw conclusions. This point is verified by a comparison of the first and second evaluations undertaken on this caseload project which indicate positive changes with continuity and, in some areas, improvements increasing over time (Page *et al*, 2001; Beake *et al*, 2001).
- 3) An assumption should not be drawn that the qualities of the midwife bear no relation to the quality of her working conditions and expectations. Organisational features clearly enhance or constrain personal characteristics. This study found that dedicated and committed midwives were contemplating leaving midwifery rather than staying in the conventional service, which they considered unacceptable. The model should be considered successful if such midwives are retained within the profession because of it.

Minimal change and unhelpful evaluations

The second important consideration relates to the philosophical underpinnings of the pilot services and their evaluations. Although the schemes were introduced with the intention of improving the service for both mothers and midwives, many failed to embrace the fundamental challenge laid down by Winterton and Cumberlege, that of replacing the medical model of childbirth with one that is woman-centred. In Davis-Floyd's terms, this required replacing the technocratic model with a humanistic, or even holistic model (1992; 1999).

Some of the main influences on the control of childbirth, which resulted in the dominance of the medical model in England, were outlined in chapter 3. Nevertheless, such a model is not exclusive, as acknowledged in care developed in other countries (DeVries *et al*, 2001), particularly Holland (Jordan, 1993) and New Zealand (Guilland and Pairman, 1994). Nor is it necessarily advantageous, as increasing intervention rates indicate (Thoman and Paranjothy, 2001). Also, an increasing body of research highlights the value of non-technological interventions, such as support during labour (Hodnett, 1997; MIDIRS, 1995). However, despite support for alternative models, achieving a radical change, as was accomplished in this caseload project, is not easy; as *Changing Childbirth* acknowledged, “*there will, naturally, be some who oppose it*” (DoH, 1993:71).

Nevertheless, schemes introduced with relatively minor changes, such as hospital-based teams designed to minimise colleague disruption, merely ‘tinker at the edge’ of the situation. Sandall’s (1997) work and other reports suggested they generated increased levels of stress for midwives, minimal change for mothers, and disruption to all without major benefit to any (Fenwick and Morgan, 1998).

Moreover, some of the evaluations were designed to test the new model for outcomes considered appropriate to the original model, not the change intended. In this they supported a medical model of care, precisely that which was questioned by the recommended change in practice. As such, they are of limited benefit, and perhaps even destructive to the aims of more fundamental change. An example of this is Allen *et al* “*questioning the wisdom of offering home visits to women who were not ill in the light of GP problems with home visiting*” (1997:238). This comment reflected a particular way of conceiving childbirth, as a medical model. When childbirth is considered as the ‘normal’ physiological process involved in creating a family, the home becomes more relevant. In terms of gaining an understanding of the mother’s situation, in order to deliver appropriate advice and care, it may be considered essential - a situation in line with the recent government emphasis on midwives having more role in public health and health promotion (Mason, 1996; DoH, 1999). As Perkins and Unell warned, “*outside researchers*” may be blind to such fundamental issues (1997:45).

The medical model of birth is clearly reflected in questions that seek to audit continuity of care, particularly intrapartum care. In focusing on identifying whether a mother was ‘*delivered by*’ a known midwife, the following issues are denied:

- a) during uneventful labour and delivery the midwife's role is supportive rather than active. It is likely, but not necessary, that the most effective support can be more readily achieved by someone known to the mother.
- b) that in a normal delivery the mother delivers her baby, assisted by the midwife.
- c) the care provided by a 'known' midwife throughout labour, in the event of an assisted delivery by an obstetrician (forceps/ caesarean section)

In denying these issues, the reason for attempting to achieve continuity is also denied; continuity of carer is a means to women-centred care, not an 'end' in itself (McCourt and Page 1996). Also, not only is the philosophical basis questionable but even in its own terms, focusing on the person who undertook the 'delivery' rather than the care provider during labour (point c), will distort the results (see also Perkins and Undell 1997).

Due to the philosophical difference underpinning the model of caseload practice, this analysis can offer different perspectives on some of the issues, identified by the shorter evaluations, which remain central to current debates.

The value of continuity

The issue of continuity remains the central debate of discussions concerning the new schemes and, as such, reflects the 'tinkering' at the edges of the fundamental change in service delivery recommended by Winterton (HoC, 1992) and Cumberlege (DoH, 1993).

As previously noted, the aim of reducing fragmentation of care had been addressed either by providing continuity of care, usually by teams of midwives sharing similar philosophies and protocols for working, or continuity of carer, where care provision is limited to one or two practitioners. However, as Lee (1997) detailed, both concepts have been defined in differing ways, and implemented through a variety of different organisational structures, which leads to confusion for comparative assessments.

Nevertheless, it is apparent that continuity on occasions has become a feature in itself rather than part of a mechanism for enhancing the quality of care. Ironically, at times adherence to the desired feature has been shown to reduce continuity overall. Research

on midwifery teams indicated that in some cases, particularly with larger teams, the ante- and post- natal continuity of care sometimes achieved by conventional community midwifery was compromised by attempts to provide a familiar face at delivery (DoH, 1993, p.15; Wraight *et al* 1993; Todd *et al* 1998; Green *et al* 1998; Hart *et al* 1999).

Several evaluations have suggested that trying to provide continuity increased the job stress for the midwives involved (Allen *et al*, 1997). Sandall's (1997) doctoral study found that team arrangements did increase midwives' stress; however lower levels were found in true caseload models and the lowest levels in traditional community midwifery. Nevertheless, the perception and expectation of high levels of stress on midwives working with a caseload have led people to question whether continuity is important enough to women to warrant the demands placed upon midwives (Lee, 1997; Green *et al*, 1998; Hart, 1999). Placing an alternative emphasis on the other two 'c's of the Winterton report (HoC 1992) and *Changing Childbirth* (DoH, 1993), the issues of *choice*, and *control*, has been recommended (Warwick, 1997).

Evaluations that attempted to assess the importance mothers placed on being delivered by a 'known' carer suggested it did not rate very highly (Hart *et al*, 1999; Waldenström, 1998; Fleissig and Kroll, 1996; Lee, 1994). However, the methods used, particularly the use of ranking questions, raise questions about the validity of such conclusions. Splitting elements of care in the assuming they are unconnected denies the interplay between them; for example that choice may be enhanced by other issues (Kirkham and Stapleton, 2001). Common sense suggests that 'safe' 'friendly' care with 'clear explanations' and 'choice' are fundamental features of a service, not desirable qualities to be ranked alongside 'previously met midwife' (Hart *et al*, 1999). Also, statements of satisfaction with a service are influenced by expectation and experience; they cannot be interpreted as everything being 'well' and improvements not desirable (Perkin and Unell, 1997). Other studies have identified women highly valued being cared for in labour by someone who had provided care during pregnancy (McCourt and Page 1996; Perkin and Unell, 1997; Beake *et al*, 2001).

The methodological difficulties of assessing the importance mothers place on continuity are well recognised (Porter and MacIntyre, 1984; Garcia *et al* 1996, Green *et al*, 1998; Walsh, 1999), but the questions remain in the commentaries and evaluations. In particular, in their review of continuity schemes, Green *et al* raise the central question "what does it mean to 'know' your midwife?" (1998: 63:136)

The 'known' midwife : the 'known' mother

This issue received particular attention in two of the key indicators of success recommended in *Changing Childbirth* (1993:70):

- 1 Every woman should know one midwife who ensures continuity of her midwifery care – the named midwife (no.2).
- 2 At least 75% of women should know the person who cares for them during their delivery (no.5).

An understanding of the situation is confused by the variety of definitions of 'known midwife' found in the literature and lack of homogeneity in even one situation. For example: in Perkins and Unell's (1997) study definitions used by professionals were either "a woman having met her midwife before" or "close personal relationship between mother and midwife"; the mothers themselves valued "meeting the midwives a few times". Also, as Green *et al* (1998) noted, many evaluations did not define what they meant by 'continuity' or how this related to a 'known midwife'.

The government dictate for a named nurse and midwife (DoH, 1994) was "*that women must be told the name of midwife who will be responsible for their care*", the ultimate test of success being that "*women can say the name of their midwife*" (The Patient's Charter Group, 1991). Lee (1997) contrasted these rather empty statements with Flint's (1995) suggestion of "*being and becoming the named midwife*" involving a personal and cosy "*relationship of trust*" between midwife and mother. What may be the key words in the quotes, 'responsibility' and 'trust', have been overlooked. The significance of "responsibility" (DoH, 1994), the issue of 'ownership' as accepting responsibility for care, and the concept of 'knowing' as a developing process of "being and becoming" over time, are rarely considered in association with 'knowing' in the literature.

Perhaps it is more helpful to consider the alternative side to the question. Rather than asking what does it mean to 'know' your midwife, identification of the implications for the midwife of 'knowing' a mother may prove more fruitful for service development considerations. From the findings of this study some of the benefits of the situation become transparent.

‘Knowing’ for the caseload midwives meant having clinical, social and psychological knowledge about the mother. Such knowledge would deepen over time, continuing into subsequent ‘maternity care episodes’. This held important implications for care delivery:

- Repetition in history taking was avoided. Information was built on and developed, as opposed to being repeated, with each visit.
- When called by telephone midwives could ‘put a face to the name’ and were able to assess the nature of the call in the light of their understanding about the individual and her circumstances. Care then provided was both ‘personal’ and appropriate.
- Knowledge about each individual enabled appropriate care delivery to be more easily achieved. For example: caring for a distressed mother during labour; where the actual source of distress may be understood (e.g. maternal fears about the baby’s parentage, or past sexual abuse), as opposed to assumed to be physiological and related to purely physical pain.
- It involved issues of security. When attending a mother at home at night, the midwives would know where they were going and who in the mother’s family would be available to meet or accompany them in potentially insecure situations.
- The relationship developed over time, with important facts only being highlighted as trust deepened. For example, previous sexual abuse was only disclosed very late into the pregnancy. With some studies suggesting a 1:3 rate for abuse and domestic violence (Aldcroft, 2001; Gutteridge, 2001) the implications for practice, and mothers, are profound.
- As the midwives’ ‘knowing’ extended into mother’s subsequent pregnancies, they were able to base advice given on their shared past experiences.

‘Knowing’ for the midwife also involved a reciprocal relationship. This had important implications for the midwives themselves and the sustainability of their work:

- Although the extent of personal disclosure was in the control of each midwife and varied according to individual and situation, the midwife was related to and respected as a person, not merely a role.

- The significance of such reciprocity for the positive psychological well-being of both mother and midwife has been discussed in chapter eight.
- On a more practical level, mothers respected a midwife's personal time and tended not to disturb them during 'unsocial hours' unless in an emergency. The midwives suggested some mothers even delayed going into labour until 'their' midwife was available, either the next morning, after a weekend off or even a holiday. Although the issue is highly speculative, the midwives perceived this and considered the mothers were responding to them. Such ability to delay labour until safe or 'convenient' is supported in studies of primates (Trevathan, 1997).

This study offers a more profound understanding of the nature of 'knowing' in clinical practice. As can be seen, these characteristics are not necessarily related to the depth of personal involvement of mother or midwife in the relationship, as the factors identified would apply to even the more 'professional' relationships. 'Knowing' becomes a part of the *process* of caseload care; it is not a feature *sui generis*.

Continuity and caseload practice

The 'cost' to midwives of providing the high levels of continuity of care achieved with caseload practice has frequently been questioned (e.g. Allen *et al*, 1997; Green *et al*, 1998), the perception being that it is unsustainable. However, it was clear that providing continuity of care was fundamental to the job satisfaction levels these caseload midwives achieved and that they considered it made their work easier in many ways. Although difficult at times and requiring considerable flexibility, contrary to perceived wisdom, providing continuity of care could be seen as a source of a reduction rather than generation of stress. However, it is likely that this was achieved because of the particular features of this model; it would not necessarily apply in the same way to everyone – since some midwives' personal circumstances might make flexibility particularly stressful.

The implementation of caseload practice in this study involved a fundamental change in midwifery practice. The features of autonomy, responsibility, continuity, and flexibility, in relating to a defined caseload, were found to be symbiotic and iterative, developing over time and providing strength and sustainability as well as safety.

Implementation of 'parts' of the package, as has been undertaken elsewhere, alters the 'balance' and is likely to generate stress and prove less sustainable.

For example: Pankhurst's (1997) study of the Brighton scheme indicated that midwives remained attached to GP surgeries, resulting in variable and unpredictable caseloads. They were also used as a reserve workforce for the hospital, providing cover for both the labour ward and clinic as well as their own caseload. The necessity of having to keep working after a night up with a delivery because of the requirement to run a routine clinic, or difficulties finding someone to 'cover', were features of many schemes and reported by the community midwives in this service studied. Such constraints severely affect the midwife's flexibility and prevent her 'making the job work for her'.

This study of caseload practice strongly supports the findings of Sandall (1997) who, in examining three different models of care, identified occupational autonomy, social support, and developing meaningful relationships with women as key issues necessary to sustain continuity of carer schemes. Similar themes emerged from this study. When considered with other emergent themes, an attempt has been made to unpack the issues further by focusing on the implications of control and use of time, and the significance of reciprocity in 'meaningful' relationships. Support, both professional and domestic, remained an underlying theme throughout the study. The importance of Sandall's key themes has been reiterated by Hunter (1999) who drew on her oral history work with pre NHS community midwives to consider their sources of job satisfaction and stress in relation to Sandall's findings. Despite carrying caseloads which would be unacceptable today, and working without the backup of partner or group practice, these midwives reported gaining immense satisfaction from their autonomy of practice, their sense of position in the community and the relationships they formed. Hunter concludes the themes of autonomy and meaningful relationships with clients were as relevant to sustaining pre-NHS midwifery practice as they are today. In my personal work with Traditional Birth Attendants it was clear that such issues were also highly relevant to them. The 'embedded' relationships developed by assisting the deliveries of generations within small communities, and the respect accorded to them for their work, were tangibly different to the relationships formed by the government health workers in the same communities. Such evidence is highly suggestive of these issues being fundamental to the work of a 'mid wif'.

In the wider context of midwifery work, such findings are supported by Mackin and Sinclair's (1998) study of midwives' experience of stress on the labour ward. They

identified generally high levels of stress, which were associated with lack of control, lack of autonomy, problems in inter-professional communication and too little time to perform their work to their personal satisfaction. They also saw the emotional demands of caring for labouring women as a source of stress (Mackin and Sinclair, 1998), rather than the source of satisfaction identified by caseload midwives. Conversely, Hunter's (1999) study of student midwives found that they did not find the emotional labour of caring for women giving birth or labour problems as stressful. For the students, the sources of stress they experienced related to the behaviour, negative relationships and ways of working of the qualified midwives they had to work with (Hunter, 1999). The "*role deprivation*" (Benner, 1984) experienced by labour ward midwives, in their inability to undertake their work as personally desired and considered acceptable, encourages the adoption of an alternative role, that of the obstetric nurse identified by Mason (2001).

Mackin and Sinclair's (1998) study reflected many of the issues observed and personally experienced whilst undertaking clinical duties during this study of caseload practice. When reflecting on the sustainability of caseload practice, the enduring question always arose as: why did midwives stay in the hospital service? If any of the three models observed appeared unsustainable the hospital model appeared most insecure in terms of midwives' distress and high attrition rate. When asked informally why, despite their obviously high levels of stress and low morale, the midwives remained, the response invariable related to financial commitments; they just could not afford to leave.

Caseload midwifery: a sustainable model

In considering the sustainability of caseload midwifery, it is important to recognise that the service in which it is delivered and the individuals who deliver it are not 'static'. The model studied here was evolving and changed in response to alterations in the service management and composition of the group of midwives. Such flexibility is likely to prove a major contribution to the sustainability of the model. Identification of the features that promoted this is helpful.

A supportive and facilitative rather than controlling management ethos, structure and philosophy of practice were seen to be central to the model, encouraging a sense of ownership amongst the midwives. Organisational features that promoted autonomy, responsibility and continuity of care also contributed toward this. An emphasis on

‘learning’ rather than ‘having to know’; reflection on practice aided by regular peer review and audit of care, and the facility to organise seminars as the need arose helped maintain the vibrancy of the midwives’ practice. The provision of appropriate administrative, practice and management support was necessary to enable the midwives to function appropriately.

Constraints such as working imposed duty rotas rather than negotiation with partner and group, having to attend regular clinics rather than arrange individual visits, and being used as a ‘reserve work force’ for hospital, would clearly place additional, and unnecessary, strains on the midwives, as would inflexible and ‘heavy handed’ management. Such constraints would prevent the midwives in developing appropriate ways of working that made the job sustainable for them individually

A positive environment was also important. New schemes and inexperienced midwives are vulnerable and require extra support and encouragement. The backbiting and open criticisms highlighted by Leap (1997) and Kirkham (1999), or the condemnation of ‘unsafe practice’ made by colleagues (medical or midwifery) before fully appreciating a situation, as reported and witnessed during this study, does little to promote professional confidence and development.

Clearly this style of working appeals to some midwives whilst others will not desire or be suited to caseload practice. Personal characteristics, particularly adaptability, flexibility, and good communication skills appeared important and were further developed through experience in this style of practice. Midwives deeply encultured in a technocratic, medical model of care, are more likely to find this mode of working difficult and stressful. However experienced, the necessary adjustments involved in a change in territory, use of time, and clinical adaptations can be problematic. Unable to pass responsibility or rely on colleagues to make decisions, in effect to ‘hide’ as in conventional services, individuals are forced to confront their abilities as a midwife. Compelling reluctant practitioners into this style of work is unlikely to help them through the adjustment period and would be ill advised – for the sake of the mothers and midwife. Students who experienced caseload practice during their training are likely to fit more readily into this way of work.

Caseload practice may be viewed as ‘freeing’ midwives’ time and enabling them to combine their social and professional lives to the benefit of both. Conversely it may be

viewed as burdensome, constraining a personal life. The balance between the two positions is very fine and may be 'tipped' from one to other, for example, by an inappropriate workload, such as too large a caseload or lack of support to cover illness or maternity leave. Also particular circumstances, such as family commitments that alter over time may cause midwives to review their personal situations and leave caseload practice, albeit for a limited period.

Caseload midwives do not work in isolation; they were clearly part of a team, of several teams:

- their caseload colleagues, who offer immediate support and advice by phone or personal contact,
- their hospital-based colleagues, both medical and midwifery, who provide expert advice and additional care where required,
- their community colleagues, the mother's GP, Health Visitor, Social Services Supporters and a wide range of professional and community services,
- the mother and her family, who may provide unexpected sources of support (Benner 1984) and without whom the midwife would be redundant.

Each of these teams contribute towards supporting, and are supported by, caseload practice, providing the strength and stability to help maintain a sustainable service. Nevertheless, the abilities of individual midwives to adapt and determine ways of working that suited their personal circumstances were fundamental. Clearly defining their boundaries, both professional and personal, to themselves, their colleagues, mothers and their families on their caseload, and their domestic partners was essential for personal sustainability in carrying a caseload.

Once these features were present, midwives were seen to gain enormously from this style of working, both professionally and personally. The organisational features of autonomy and continuity supported the midwives development towards becoming expert practitioners (Benner, 1984) and they reported experiencing high levels of job satisfaction. Their positive involvement in their work and issues of reciprocity suggest caseload midwifery may be a highly sustainable model of service delivery, of benefit to both mother and midwife.

Chapter 12

CONCLUSIONS AND IMPLICATIONS

This final chapter synthesises and integrates the key themes of the study and places them within the framework that has been developed throughout the thesis. The implications of these findings for practice and service development are outlined. The methodology is critiqued by reference to the strengths and challenges of the study, and areas for further research delineated.

It will be argued that in caseload practice midwives were ‘given back’ features of their work that had been subsumed within the institutionalisation and increasing medicalisation of childbirth. This study indicated that carrying a caseload presented a ‘hidden’ and, as portrayed in the bottom layer of the iceberg, fundamental challenge to all practitioners, offering the potential for re-defining the nature and experience of midwifery and the development of a new form of midwifery professionalism. The study also illustrated the way in which organisational features can influence the practice and meaning of midwifery. In particular, the provision of continuity of carer, if properly supported, forms the fundamental basis for the success and stability of caseload practice. However, caseload midwifery is not about independence. It was seen to be about the creation of teams - involving mother, midwife and obstetrician, and the relationships involved in this, and about power and reciprocity, and support.

This thesis does not argue that the model studied is the only way to practice midwifery; it does contend that caseload practice presents a viable option for midwives.

Although setting the context for the development of caseload midwifery, the summary presented in the following section provides an understanding of why the study indicated in many ways that midwifery has come ‘full circle’. However, this thesis argues this is not a complete circle but a spiral in which the strengths of traditional models are drawn on and combined with positive features of modernity which include the appropriate use of technology.

From mid wif to midwife to mid wif - the changing role of the birth attendant

During the past century technological developments have both enabled and supported an increasing 'globalisation' of many aspects of society. Ideas and practices concerning childbirth have not remained unaffected by this movement. The dominance of western notions about pregnancy and birth have been promoted through education and example, and further disseminated by the use of the internet. English is the international language of science and an English-style medicalised model of childbirth promoted as the "*authoritative knowledge*" (Jordan, 1993) and solution to high mortality rates. (de Brouwere *et al*, 1998; Kamal, 1998; see also Wagner, 1997)

This transfer of knowledge also involves the exportation of ideas that have been found problematic for mothers and their birth attendant and, given the iatrogenic effect of routine intervention, potentially detrimental to childbearing. In England these arose as a consequence of changes in British society that resulted in a movement of childbirth from the private to public domain. The movement was partly due to developments in technology perceived to assist birth, the control of access to these by the medical profession, and the development of a welfare state that facilitated that access. The relationship between mother and midwife was weakened by attempts to professionalise the occupation of midwifery at the beginning of the century, and undermined by alterations in the 'economic exchange' of the midwife's labour, particularly with the implementation of the welfare state and NHS. This situation was compounded by the increasing institutionalisation of childbearing. Childbirth became removed from its social situation to form one of the 'dis-embedded' (Giddens, 1990) features of modern life.

The institutionalisation of birth facilitated a medicalisation of the childbirth process with a consequential 'objectification' of both mother and midwife. The person of the mother became lost in a focus on the medical 'process' of childbirth, and the person of the birth attendant, the midwife, subsumed within a Taylor-Fordist (Doray, 1988) task-oriented role that helped support the 'production line' producing 'live healthy babies'. The previous autonomy of midwives, and much of their role, was lost as obstetricians assumed a sense of 'ultimate responsibility' for care provision.

The validity of the objections raised by mothers and midwives who sought a balanced alternative to the interventionist approach of obstetrics were acknowledged by the Select Committee (HoC, 1992) and subsequent Expert Maternity Group (DoH, 1993). Their recommendations to address the problems presented a radical change from the medical hegemony by placing mothers at the centre rather than periphery of care and acknowledging their right to exercise choice and control in the decisions made concerning that care. The benefits for mothers to establish a relationship with their care-provider were recognised and provision of this recommended. Hospitalisation of all birth on the grounds of safety was not supported, and the role of the midwife as appropriate care-provider for normal childbirth re-affirmed. These recommendations received government support and became adopted as policy for the maternity services.

This promised to alter the fundamental philosophy of childbearing, and required a radical change to the organisation of maternity services. Women were no longer to be dominated by a scientific rationalism that ignored their individuality and experiences, and midwives were 'given back' their role as birth attendants supporting the needs of mothers rather than those of an institution. Many of the older midwives commented on the system of care going 'full circle'. However, whilst the new ideology was well supported, the practicalities of implementing such a radical change generated concern, particularly over midwives' willingness and abilities to undertake a different style of practice. The state had 'given back' to midwives their responsibility with normal birth and the facility to work in a more 'traditional' manner, but the consequences of this change for the individuals delivering such care and the wider maternity service were unknown.

The key recommendations of the Expert Maternity Group were operationalised within the model of caseload midwifery that formed the focus of this study. Twenty midwives, trained and experienced in a highly medicalised maternity service were given responsibility to provide midwifery care to 40 mothers per year irrespective of associated risk factors. In facilitating mothers' choice for care to be provided in community or hospital, the midwives were effectively 'taken out' of the institution and placed 'with' the mothers, to work as, when and where required by their caseload. Liaison with other professionals was fundamental to their work, but care of normal pregnancy and birth, wherever provided, was the responsibility of the midwife, not an obstetrician.

The consequences of this change were carefully evaluated, this thesis being drawn from the arm of the study that focused on the implications for professionals delivering care. Insights gained from this analysis offer important perspectives on midwifery, particularly the interplay between organisational features and practice.

The significance of mid wifery

One of the intentions of the model was to facilitate the re-development of the role of midwife, 'giving back' to midwives features of their work that had been subsumed within the institutionalisation and increasing medicalisation of childbirth. Caseload practice fulfils the ideology of midwives as autonomous practitioners delivering all aspects of midwifery care to individual mothers; an ideology promoted in training and supported by legislation but generally experienced as otherwise (Robinson, 1989; Hunt and Symonds, 1995; Davies, 1996; Kirkham, 1999) and observed as such in this study site. Such conflict proves a major source of frustration to many midwives. Several of the caseload practitioners reported seriously considering leaving midwifery had the project not been implemented, indicating that such problems may contribute towards an attrition of highly motivated midwives who are not prepared to tolerate the frustrations experienced within conventional services.

The model was found to have been highly successful with the midwives delighted that they were able to practice what they termed "*real midwifery*". Such response begets questions concerning the 'midwifery' they had been practising within the hospital and community services. Analysis of the adaptations experienced by midwives entering caseload practice highlights many of the differences between the models, and illustrates the way in which organisational features can influence the practice and meaning of midwifery.

In caseload practice responsibility, autonomy and continuity were identified as the central organisational influences, supported by the partnership and group structure. The significance of these are perceived as follows.

In being given responsibility for all midwifery care of a defined number of mothers, rather than responsibility for a defined area of work, be it a department within the hospital or geographical location in the community, caseload midwives are encouraged

to focus on the individual as a whole rather than specific tasks. All aspects of midwifery are practised on a regular basis and in a variety of situations, according to the needs of individual mothers. Without the constant presence of obstetricians or senior midwives to refer, or defer, to, accepting responsibility for care 'forces' midwives to make decisions and motivates them to obtain the skills and knowledge required by providing an immediate meaning and purpose to their learning.

The "*steep learning curve*" identified as part of the transition into caseload practice reflects the reality that, although initially trained to undertake such work, the experiences of hospital-based midwifery, in particular, promote an ossification of these abilities. Periodic rotation through different departments encourages a transient expertise in specific areas, which diminishes on moving elsewhere. Expertise in the 'whole' is never achievable and, as Schön (1983) suggested, encourages a 'parochial' narrowness of vision.

Moreover, caseload practice requires midwives to 'situate' their practice by applying and adapting it to meet the needs of specific mothers. Knowledge of individual situations challenges consideration of the applicability of procedures accepted as routine in the hospital. This forces an identification and application of principles rather than rote delivery of standard procedures, thus combining the 'art' with the 'science' of midwifery practice. In promoting a task rather than person orientation, the development of such skills is not facilitated within hospital-based practice.

The second organisational feature, autonomy, is seen to be crucial for the development of a way of working that meets both the needs of the mother and the midwife. Autonomy relates to 'quality' and 'flexibility' – of care provision and lifestyle. In being given autonomy of practice midwives are no longer controlled by a hierarchy imposing particular routines that meet the needs of the institution rather than mother or practitioner. Instead, the expectation of what is to be achieved is defined but how this is to be achieved, within the limitations of accepted midwifery practice, is within the midwives' control, to be negotiated with mothers and their partnership. This enables midwives to find ways of working that suit them personally.

'Ownership' of time was seen to be one of the defining features of autonomy. When given back 'their' time, with the constraints of duty rotas, unsocial-hours claims and fixed clinics removed, caseload midwives are able to use it in a way that best suits

themselves and their mothers. This is more than just a 'convenience' but affects quality of care, for example: by facilitating home visits in early labour that support the physiological time of birth rather than controlling it in hospital through routine intervention.

Autonomy also enables midwives to engage in their work, particularly in the decisions they make concerning care provision. It encourages an involvement of the midwife's self, allowing a creative aspect of their work to emerge, something which is suppressed by routines and the expectation to follow imposed protocols. The potential is for more appropriate care for mothers and greater satisfaction through a realisation of personal expectations and self-actualisation for the midwife.

The third, and this study would indicate fundamental, feature of the model is continuity. Caseload practice in this model is synonymous with continuity, no 'false' distinctions between continuity of care and carer being drawn. One midwife takes responsibility for providing midwifery care to a set number of mothers and, as far as is reasonably possible for individual practitioners, provides or supervises that care. This feature proved the basis on which the issues of responsibility and autonomy are actualised and hold meaning. Without it neither are as significant.

Continuity also facilitates the delivery and refinement of midwifery care. It gives meaning to the midwives' work as familiarity with particular situations facilitates provision of appropriate care. Repeated contact enables assessment of care, facilitating modification or change as indicated. Time spent in planning and preparation with each mother, particularly about birth, becomes an 'investment' where midwives also benefit. In the partnership arrangement, midwives have an assurance that care discussed will be provided, most likely by themselves, giving them the opportunity to assess the preparation and the satisfaction of recognising when it was appropriate and thorough.

Continuity also enables the development of 'meaningful relationships' if desired by both parties. The repeated contact facilitates the process of midwife and mother getting to 'know' each other and the individuality of both can be acknowledged and appreciated rather than denied. This holds the potential for the development of a more engaging and fulfilling role for midwives.

However, the social component of 'being with woman' as needed, also raises the possibility of the development of dependency relationships and inappropriate

expectations of the midwife, expectations held by the midwife herself and her clientele. The different relationships formed with mothers challenge practitioners into defining the exact nature of midwifery or, more practically, what it is not. Within conventional services such boundaries are defined by the organisation rather than the individual, through placement and duty rotas and a hierarchy of responsibility and control. By not defining their boundaries appropriately, midwives are in danger of embracing the ideology of caseload practice then experiencing difficulties in supporting the commitment they give their work. Once such boundaries are acknowledged and mothers on their caseload "*educated*" accordingly, midwives' lives and work can become 'balanced'.

Balance in power is also an important characteristic of the midwife-mother relationship. The acknowledgement of the individuality of both midwife and mother encourages the development of a reciprocal relationship that, it has been argued in the thesis, holds potential psychological benefits for both parties. Such reciprocity may prove an important counterbalance to work stresses experienced by midwives.

In moving the loci of control from institution to midwife, caseload practice facilitates a movement for mother and midwife from positions of subservience to ones where choice and control over situations can be exercised. This raises the potential for midwives to exercise a newly found 'power' over mothers, a characteristic that in this study never appeared realised. It also enables midwives to learn from mothers, in particular learning to respect when action is not required, when watchful 'inaction' is the most supportive frame for childbearing, an ethos at complete variance with the 'managerial' interventionism of the hospital service.

The honing of midwifery skills and development of alternative perspectives and knowledge about childbirth gained through working 'with' mothers enables midwives to develop a form of authority that is not facilitated within the conventional hospital or community midwifery models. This authority is considered in this thesis as a new form of midwifery professionalism developed in conjunction with mothers. Such professionalism within midwifery holds significant implications for the dynamics of relationships and exercise of power within the childbirth arena.

Caseload practitioners do not work in isolation but in collaboration with other professionals. Effective communication skills are essential, particularly as they develop and re-negotiate relationships within their group and the wider community, both professional and non-professional, that serve the needs of mothers. The success of these relationships contributes to the support, stability and sustainability of caseload practice.

Particular strength is gained from the partnership and group organisation. This necessitates midwives taking responsibility for each other and resolving frictions as quickly as possible. Such responsibility encompasses professional issues concerning colleagues' practice as well as their personal well-being. The requirement to assume such responsibility and the importance of effective colleague relationships is seen to be less valued in hospital-based practice. There, defined roles and expectations structure individuals' responsibilities which tended to be task rather than person orientated. This enables dysfunctional relationships to be subsumed within the wider organisation rather than resolved, without undue disruption to care provision (Leap, 1997; Kirkham, 1999). From the complaints made about the unexpectedly "*political nature*" of their work and the disruptive problems experienced within the groups it was apparent that the caseload midwives were initially neither fully aware of the centrality of, nor experienced in, the development of 'effective' professional relationships. Such skills were honed with experience but had clearly not been developed in the conventional services.

Support from management in working this way is also crucial. The organisational features of partnerships and group practices, a common ethos and standard of practice, and a facilitative management style help provide such support. Fast resolution of difficulties experienced within the partnerships and group is essential and occasionally specific support may be needed with this. Expertise is also required for the development of skills necessary for caseload practice, e.g. home births, although with increasing experience this may be found within rather than external to the group.

This research is highly suggestive that the provision of continuity of carer, if properly supported, forms the fundamental basis for the success and stability of caseload practice. The high levels of job satisfaction reported, and consideration of the issues of reciprocity and being valued as a person rather than a 'pair of hands', were indicative of positive psychological outcomes for midwives and the possibility of reduced stress levels to those experienced by their colleagues in the conventional service. Caseload

practice is clearly stressful at times, but the midwives defined it as a different sort of stress from that they had experienced within the hospital service.

For the midwives concerned, caseload practice was not merely the transposition of skills and attitudes into a different setting, but presented a fundamental change to the meaning of midwifery for them and the mothers they care for, as portrayed in the bottom layer of the iceberg. This has been acknowledged in the use of the Anglo-Saxon term 'mid wíf', adopted in recognition that this style of midwifery held many similarities with the work of Traditional Birth Attendants and was likely to hold such similarities historically. However, the complexity of modern society both requires and facilitates that, unlike their predecessors, such practitioners do not work in isolation but as members of a team in which the contribution of all parties, including the mother, are valued equally.

Caseload practice is not concerned with returning to a 'more natural' form of childbirth, promoting homebirths or alternative therapies, as feared by the obstetricians and desired by some student midwives. It is about relationships, about power and reciprocity, about support – for all members of the team, mother, midwife and obstetrician as they are inextricably entwined in the provision of safe care for mothers and their babies. Technology remains an important feature in the childbirth arena, but used within relationships of equality may support rather than dominate the experience of childbearing.

An appreciation of this position presents a challenge to many societies. For, in seeking modernity and safety in childbirth, many are rapidly adopting western notions of a medical hegemony and forsaking that which 'the west' now values and is seeking to re-attain – care provision during childbirth by a known attendant; something this study indicates can benefit midwife as well as mother.

Implications for practice and for service development

The particular value of this study is that it has been situated within a wider, extensive evaluation of the model that provided detailed information concerning other aspects of its effectiveness. These indicated it was popular with mothers, that positive clinical outcomes were achieved and that it was cost neutral and likely to be cost effective (McCourt and Page, 1996; Beake *et al*, 2001). In confirming the effectiveness of this model of caseload practice such findings support the argument of this thesis, that

caseload midwifery is a viable option for the maternity services to develop and that it holds particular benefits for midwives as well as mothers

In terms of service delivery, caseload practice may be viewed as a particularly efficient service; midwives' skills are fully utilised in a way not achieved within the conventional service, and in working to meet the needs of mothers rather than the institution a more efficient use of their time is achieved. However, this system lacks a degree of flexibility by only accommodating a defined number of mothers; caseload numbers per midwife cannot be adjusted according to variations in booking numbers. If caseload practice were to be 'rolled out' across a maternity service specific arrangements would be required to accommodate such variation, perhaps within a parallel service.

Alternative forms of service delivery will always be needed to meet the varied requirements of mothers, ranging from high tech. intensive care facilities to the facilitation of home births. Midwifery care will be required in all such situations, indicating the potential for the development of a variety of styles of organisation of practice. Caseload practice is one amongst several, each offering particular advantages and disadvantages.

As previously argued, caseload practice is neither an elitist nor exclusive service but presents an alternative option, implemented alongside others designed to meet the range of needs that mothers may require. As it may attract midwives who, frustrated with conventional services, are contemplating leaving the profession, implementation of this model extends the range of options available to meet the needs of midwives, and may help reduce the current attrition rate.

The sceptical argument suggests that such models of care are only sustainable by highly motivated midwives who are unique in some manner. However, this study indicates the situation is rather circular with the model both attracting and creating motivated midwives. This clearly indicates the effect of organisational features on the development or control of midwifery skills and practice. Caseload practice was seen to have important positive effects on the development of midwifery practice, and of the individual midwife. High levels of job satisfaction and, it is suggested, of reciprocity and self-actualisation contributed towards the midwives' positive orientation towards their work and level of motivation. Conversely, in the conventional service where midwifery practice was undermined and devalued, the midwives were seen as

demoralised and de-motivated, resulting in those with economic and domestic freedom tending to move on, with the more motivated ones contemplating leaving the profession. The ideology of midwifery, as opposed to nursing, is likely to attract individuals who are seeking responsibility and autonomy. Disillusioned with the reality experienced they leave midwifery. Caseload practice presents an alternative option.

However, as a style of practice that demands a re-orientation towards life in general not just work, as discussed in relation to the conception and use of time, caseload practice is not suited to everyone. The value of short trials for example, undertaking maternity leave cover where interested midwives can 'test out' the system without prejudice, was highlighted. Neither is it likely that caseload practice would be suited to one individual at all stages of their life career. Changes in responsibilities and personal circumstances may present periods when a more structured approach to work proves more compatible.

The study indicated that caseload practice presented a threat to particular groups working in the maternity service, notably obstetricians closely involved in the care of 'low-' as well as 'high-risk' childbirth and community midwives. Such tensions present a dilemma for managers as the development of a more efficient service may be constrained by political arguments. Nevertheless, this study re-emphasised the dis-economies of duplication of care that have been highlighted by reports into the maternity services since the introduction of the NHS (MoH, 1959; DHSS, 1970; HoC, 1980; HoC, 1992; Audit Commission, 1997). Midwives are expensive 'handmaidens' to obstetricians and obstetricians proved exceedingly expensive and, for example acknowledging the questionable benefits of hospital-based antenatal care in 'low-risk' pregnancies (Audit Commission, 1997), considerably less efficient, than midwives. Both professions are essential to the support of safe and fulfilling childbirth; both professions rely on the services of the other (RCOG and RCM, 1999). However, they are different occupations. Caseload practice acknowledges that difference.

The tensions generated with community midwives are more of a challenge for service development as caseload practice presents an explicit devaluation of their role. Nevertheless, the place for a limited traditional community service may remain although sensitivity will be needed to ensure it does not become a 'second rate service' serving just to 'mop up' those who could not be catered for by the caseload midwives. Similarly, tensions with their hospital midwifery colleagues were generated by caseload practitioners filling a more 'consultancy' type role for mothers admitted to hospital and

being considered to 'use' their hospital colleagues. Avoidance of such 'them and us' elitism is clearly important. Re-configuration of the ward skill-mix with a larger proportion of Health Care Assistants, and even cleaners, may be indicated to cover all non-midwifery services in such situations. Also, appropriate recognition and development of the specialist skills required for hospital midwives working in high tech. areas would help avoid any sense of devaluation presented by caseload practice.

The divisive potential of caseload practice is reduced when caseloads comprise of 'high-' as well as 'low-risk' mothers. The opportunity for exchange of ideas and information – between hospital and caseload midwives, and midwife and obstetrician – are enhanced and the potential for the development of a sense of exclusivity in 'normality' denied when caseload midwives also care for 'high-risk' mothers. It may also preclude the development of an occupational ethnocentrism that denies the value of alternative style of practice. Such situations demand team-work and help break down or prevent the erection of barriers that could develop with the image of caseload practice as separatist and elitist. As previously noted, successful caseload practice necessitated teamwork and this is more likely to be achieved with frequent contact with colleagues working in other aspects of the maternity service.

It was clear from this study that caseload practice holds the potential for redefining the meaning of midwifery, the development of body of midwifery knowledge and the emergence of a new form of professionalism. However, these cannot be taken as axiomatic. Specific organisational features support such development; in particular attention paid to the philosophy of the group, structural features that aid flexibility and effective supervisory rather than disciplinary management.

Within the caseload service commonality of ethos and of practice was seen to be important and likely to be central to sustainability of this model. Investing resources in the creation of such commonality, through 'awayday' meetings and peer review, should be recognised as vital in the establishment of a supportive mutuality, a 'pulling together' and awareness of each other that is fundamental to the model and satisfying for the midwives. The knowledge that colleagues provided 'similar' care encourage midwives to 'share' work rather than maintain an exclusivity of care that would be unsustainable.

It also provides an important safety feature of the model; an awareness of and participation in colleagues' practice helping to avoid isolationism where standards can slip or poor practice pass unnoticed. Commonality once established needs to be sustained, particularly with staff movements. It is not a 'once off' part of an implementation or an 'extra' to be cut when budget constraints tighten but an important catalyst in the maintenance of a service based on mutual support and philosophy of care.

As previously noted, specific organisational features that enhanced flexibility were essential components of this service. Responsibilities that tie the midwife, such as regular clinics or meeting the needs of the hospital as a reserve work force, destroy the fine balance that enables the midwives to 'make the job work for them', the fundamental issue for sustainability. Also, the use of an annual extra payment allowance release midwives from the economic constraints of overtime or unsocial hour payments. As well as offering a defined sum for management budgets, this facilitates a flexibility that enables midwives to work when convenient to themselves and their women rather than the service budget.

The requirement for managerial support, particularly with cover arrangements or replacement during sick-leave or absence of more than a few days, may demand particularly imaginative responses. Absence within a larger service places an additional strain that can, with relative ease, be spread over a number of people; in caseload practice it falls on few shoulders and cannot be sustained for long without additional support.

It was clear from this study that caseload practice demands skills of midwives that have not been honed within conventional services. Support for this development is imperative, particularly in the implementation phase; once established, internal mechanisms of support and skills transfer would be more readily available from the experienced caseload practitioners. An ethos that encourages learning, testing ways of working and new ideas, supporting rather than controlling or imposing ideas helps promote the development of initiative and a sense of responsibility within the group members. The more hierarchical managerial ethos of conventional NHS hospital services clearly tend to squash such resources (Stapleton *et al*, 1998) although for midwifery the value of supervisory as opposed to disciplinary procedures holds enormous potential.

However, it is difficult for managers to promote such a supportive ethos when they themselves remain tightly controlled. In their analysis of the successes and impediments to midwifery service developments the SNMAC (1998) highlighted the importance of midwifery managers have a 'voice' that can be heard within the senior management structure, having what Stapleton *et al* (1998:225) defined for supervisors as "*clout*". In this study a movement towards a more 'controlling' ethos and reduction in the input of the Head of Midwifery to the Trust Board, was recognised and contributed towards the diminution of the caseload midwives 'trust' in the Trust as their employer. The consequences were reflected in the attrition rate and the remaining midwives' deepening concern when the project manager left at the end of the data collection period.

Such lack of trust and effective communication between management and caseload practice may create further problems when disputes arise concerning care provision. Despite the obstetricians assumption for 'ultimate responsibility', midwives have been legally responsible for their practice since 1902 and continue to be so (UKCC 1998), 'proving' their competency with adherence to the requirement of PREP (UKCC, 1999, 2001). In practice this responsibility appeared more rhetoric than reality in this study site, as well as others (Davies, 1996). However, with the 'new professionalism' demonstrated by the caseload midwives comes the requirement to accept responsibility. Given the current trend towards increased litigation (Diamond, 2001), it is likely this will cause an increase in charges against midwives. A counter argument suggests increased individualisation of care and sense of involvement by the parents may mitigate against this (Benner, 1984). Nevertheless, an increased potential for being sued remains, highlighting further the need for the development of appropriate, supportive and 'empowering' supervision (Stapleton *et al*, 1998:ch.8) as opposed to the 'controlling' ethos with which it originated (SNMAC, 1998).

Finally, the environment in which caseload practice is developed requires consideration. The perspective of childbirth as normal only in retrospect is a feature of medicalised childbirth (Davis-Floyd 1992) the desirability of which was questioned by the Winterton report (HoC, 1992). In reviewing the evidence, the committee determined that further improvements in maternal and neonatal mortality rates were more likely to ensure from improvements in other forms of "*social advance and support for mothers*" (HoC, 1992 p.lxv) than increases in a medical involvement in birth. Their support for a

more midwifery orientation towards birth was strong. Alterations to the dominant philosophy cannot be changed overnight. However, the requirement to change needs to be acknowledged and supported in the design of new projects such as caseload practice, rather than ignored - as appears more common (see chapter 11).

It may be that caseload midwifery practice sits more comfortably within the Public Health arena (DoH, 1999; Hunt, 1997) where a stronger appreciation of midwifery appears to be held (SNMAC, 1998). However, this study identified particular advantages to midwives caring for 'high' as well as 'low-risk' pregnancies, advantages for both midwife and mother. Consolidating a position for midwives within the community health service may have proved advantageous, but a major strength of this particular model of practice was the midwives involvement in care provided for mothers with potentially complicated pregnancies. For thirty years midwifery has been based within hospitals, and hospital care is both desirable for, and desired by, a significant number of mothers. It is the 'institutionalisation' of that care, not the institution, that has proved problematic to mothers and midwives. Caseload practice offers an alternative approach that combines both community and hospital in the provision of care that is appropriate and sensitive to the wishes of mothers. The most appropriate 'home' for midwifery has yet to be determined.

Strength and challenges of this study

Considerations of the validity of this study and the analysis undertaken emphasise the overtly subjective nature of ethnography. This can be recognised in the way respondents related to the researcher, and the selection process inherent in the identification, collection and analysis of data. Such features are inherent in all research approaches yet are less acknowledged or accounted for in some. It is acknowledged that what was considered important for collection and analysis in this study might have differed with another researcher. However, this would have offered the potential for 'alternative', not 'better', understandings of caseload practice.

A particular challenge of the study was in conducting an ethnography within an environment steeped in the scientific methodology. An uninterested or sceptical reception of the participants, particularly obstetricians, was possible; in a highly masculine-orientated organisation research undertaken by a female midwife-researcher using a qualitative paradigm could be expected to receive a cool response. The reverse

was experienced. The apparent openness and honesty with which individuals discussed their perceptions and experiences, from clinical director to student midwife, was unexpected and welcomed. However, understandings gained through ethnography are heavily reliant on the way participants respond to the researcher and, although conducted with care, one cannot be sure that people do not mould what they say to the person of the researcher. The use of multiple methods for data collection helped to counterbalance this concern.

Clearly the potential for the research process or the findings to be skewed by the individuality of the researcher was ever present. As far as possible this was minimised by care with the manner in which the study was conducted, as discussed in chapter 2. Transparency of intent and conduct is detailed to facilitate the reader in making informed judgements concerning the reliability of the study undertaken.

The duration of the data collection period was an important strength of this study. Lasting 46 months this facilitated an understanding to develop over time that moderated the influences of particular, and time-specific events. A distinction could then be made between issues that were likely to be features of the pilot stage and those that were more enduring to this model of practice. This offers important perspectives on the ‘problems’ identified by other shorter studies, indicating the significance of the ‘transition period’ and resolution strategies which were successfully employed – with time. The duration also encompassed a considerable movement in staffing, within the project and also within the wider management who were external yet influential on the project. Such change, although difficult for the caseload midwives, offered useful perspectives on the strength of the model *per se*, helping to identify features that were fundamental to the model and those that were relational to particular circumstances or environments. These features strengthened the analysis and value of the theoretical understanding gained.

The variety of data collections methods utilised enabled a triangulation of approaches to particular phenomena; for example, the use of observation, interviews, and survey questionnaire to gain an understanding of the midwives’ personal ‘development’. Such triangulation of data collection was further strengthened by gaining the perspectives of a variety of categories of participant; all levels of the hierarchy and alternative areas of work were approached. The breadth of the study used an inclusive as opposed to selective approach whereby the views of all members of the study site were considered

of equal 'weight' and, as far as logistically feasible, sought. Where sampling was necessary (e.g. interviews with E grade hospital midwives), a secondary approach involving the wider membership, in the form of 'participation' as a co-worker, aided sensitisation to issues considered important by this group.

The depth of understanding about the culture of the organisation in which the midwives worked was aided by the facility to live on-site in the nurses' home for a considerable proportion of the study. Being 'around' at unusual hours helped a penetration beneath the organisational façade that is constructed during 'office working hours', assisting in a deeper understanding of 'what was going on' and what it was like to be a midwife in this particular service.

Although the triangulation of data collection methods and perspectives of participants plus the duration of the study helped overcome the inherent subjectivity of ethnography, particular limitations remain. It was a study of one specific site, clearly influenced by the environment and limitations of that maternity service and the strengths of the personnel who implemented the project. Also, the study was of a relatively small group of 'volunteer' midwives who elected to work in what was initially only a pilot study. Thus the findings of this study are indicative, not conclusive.

Finally, the wider evaluation in which this study was situated provided an understanding of the phenomena identified from alternative perspectives. In particular, the views of mothers and the effectiveness of caseload practice in comparison with the conventional service. Thus this ethnography both complements, and is complimented by, the findings of the evaluation and should be considered in conjunction with the evaluation reports (McCourt and Page, 1996; Beake *et al* 2001), as summarised in chapter one.

Further exploration: the next questions

There were a number of areas identified during this study that were unable to be explored in depth and would lend themselves to further research. Additional analysis of the rich data collected will address some issues not covered by this thesis. However, the analysis also generated a number of questions that could fruitfully be explored in other studies. Areas that would increase our understanding of the implications of caseload practice included consideration of the implications for caseload midwives' wider social relationships, involving partners, family and friends. Arguing that caseload midwifery

constituted a 're-embedding' of a particular service relationship in society (Giddens, 1990), the implications of this for the other social relationships the midwives form, and the rights and obligations assumed within those relationships, requires further consideration than that offered by this study.

The thesis has focused on caseload midwifery as developed and experienced by midwives previously trained as nurses and 'encultured' in a high medical model of childbirth. Clearly the experiences, although not the implications, are likely to be different when the midwives' ideas and experiences of 'midwifery' *per se* are differently informed, such as for 'direct entry' midwives, midwives whose training included a prolonged secondment into caseload practice, or midwives experienced in different styles of practice such as independent midwifery.

Although of a longer duration than other such studies, this research still focused on the early stages of a caseload practice development. A well established, 'honed' service, with a mixture of experienced caseload midwives and new entrants, and established patterns of behaviour and expectations, is likely to present new perspectives and highlight other strengths and weaknesses of this style of service. Therefore this study offers an important contribution, presenting 'baseline' knowledge from which other studies may develop our understanding of the nature and implications of caseload midwifery.

In facilitating the provision of a holistic form of midwifery care, caseload practice was seen to offer something more than that achieved when it was broken down into task-orientated departments. The ethnography, and the wider evaluation in which it was situated, suggest that caseload midwifery was highly valued by the midwives and mothers alike. To paraphrase a popular saying, the understandings gained from this study strongly support the thesis that, for the caseload midwives,

'the whole was found to be greater than the sum of its constituent parts'.

APPENDICES

APPENDIX 1: Ethics approval, re-negotiated by personal contact

Assistant Secretary (Research)

Direct Line:

Facsimile:

4 May 1995

Miss Trudy Stevens
158A Mill Road
Cambridge
CB1 2P

Dear Miss Stevens

RE: Ethnographic study of the Implementation of
Midwifery Practice

Thank you for your letter of 1 May concerning the above. I am writing to confirm that your study does not require specific ethical approval, although the programme of research of which it is part has been approved by the

Hospitals Research Ethics Committee. In giving this assurance, I am assuming that at no stage in your study will you approach patients, or examine their notes and that the study is purely examination of the response of clinical staff to the view system of practice.

With best wishes

Yours sincerely

Dr
Secretary; Research Ethics Committee

APPENDIX 2a: Questionnaire sent to current caseload midwives

Midwifery Practice: Midwives' Profile July 1997

please write overleaf if more space needed

- 1 Code:
- 2 D.O.B.:
- 3 Personal Commitments (which may influence/be affected by your work eg family, partner, studies)
- 4 Date joined
- 5 Age when joined years: months:
- 6 Qualifications, date & place obtained (professional, academic & other):
- 7 Midwifery experience prior to joining
(please indicate number of months in specific areas, and in which hospital, eg. 7months AN clinic, QCCH)
- 8a Reasons for joining
- b How have these been met?:

9 What have been your personal achievements/professional development, if any, since working in

10 Current Views. Please give the three most positive and three most negative things about working in the service (your personal view):

Positive:

1.

2.

3.

Negative:

1.

2.

3.

11 What do you consider to be the strengths and the weaknesses of the current service?

Strengths:

Weaknesses:

12 Suggestions for change:

Name

31 July 1997

Dear Name,

Re: Ethnographic Study of the Implementation of

Midwifery Practice

Please find enclosed a brief questionnaire which is designed to elicit your personal views of the service as it currently stands, as well as some basic background data about the midwives who choose to work in it.

I am using this tool as the most efficient way in which to gain a broad understanding of the current situation. Many of the issues you raise can then be explored in more depth as I work with you personally or with your group. For this reason I would be most grateful if you would complete it and return it to me in the office asap. Please do NOT spend a long time contemplating your responses (nevertheless, all essays will receive careful analysis!). Anonymity is assured by the coding system that I am using throughout my work.

Very many thanks for your help with this.

With all best wishes

Trudy Stevens
Researcher-Practitioner

APPENDIX 2b: addition to 2a for midwives on maternity leave

Midwifery Practice: Midwives Profile: Maternity Leave

Congratulations! I do hope you and your baby are enjoying the summer, and both thriving well.

- 13 When did you start your maternity leave?
- 14 Initially, when were you planning to return to work?
- 15 Initially, were you planning to return to the service? If not, where did you hope to work?
- 16 Now, do you plan to return to work, and if so when?
- 17 Do you plan to return to the service?
- 18 If yes, what difficulties, if any, do you expect any difficulties with this? How do you plan to overcome them?
- 19 If no, what do you plan to do and why?

Name

27 August 1997

Dear Name,

Re: Ethnographic Study of the Implementation of Midwifery Practice

Many congratulations on the birth of your baby; I do hope all is well and that you are enjoying your maternity leave.

As the final part of the above study I enclosed a brief questionnaire which is designed to elicit your personal views of the service as it currently stands, as well as some basic background data about the midwives who choose to work in it.

Recognising that the past experience of midwives suggests that the service may present some problems for mothers with young babies I have included a few questions that relate specifically to your views about returning to work after maternity leave.

I would be most grateful if you would complete it and return it to me using the enclosed Freepost envelope. Please do NOT spend a long time contemplating your responses as I appreciate that you have much better things to do with your time (nevertheless, all essays will receive careful analysis!). Anonymity is assured by the coding system that I am using throughout my work.

Very many thanks for your help with this.

With all best wishes

Trudy Stevens
Researcher-Practitioner

APPENDIX 2c: Questionnaire sent to caseload midwives who had left

Midwifery Practice: profile of midwives who have left

- 1 Code:-
- 2 D.O.B.:-
- 3 Personal Commitments (which may have influenced/been affected by your work eg. family, partner, studies):-
- 4 Date joined
- 5 Age when joined years: months:
- 6 Qualifications, date & place obtained (professional, academic & other):-
- 7 Midwifery Experience prior to joining
(please indicate number of months in specific areas, and in which hospital, eg. 7 months ANC, QCCH)
- 8a Reasons for joining
- 8b How were these met?:-

Please write freely overleaf if more space required

August 1997

9 What date did you leave the service?

10 Why did you go? (please be honest!)

11 What have you done since leaving the

12 What, if any, personal achievements/professional development do you think you gained by working in the service?

- 13 Please give the 3 most positive and 3 most negative things about working in the service (your personal view on reflection).

Positive:

1.

2.

3.

Negative:

1.

2.

3.

- 14 Any other comments:

To all previous

Midwives

29 August 1997

Dear Name,

Re: Ethnographic Study of the Implementation of

Midwifery Practice

I am writing to you as one of the midwives who have worked in the Midwifery Practice. As the final part of the above study I am undertaking a survey of the current views of all the midwives who have worked or are currently working in the service.

The majority of you very kindly talked in detail with me before you left. At that time I mentioned that I would like to follow up on your experiences since leaving the service; this is what I am now aiming to do.

I enclose a brief questionnaire which is designed to identify what midwives have done since leaving the service, what they felt they gained through working in the (if anything!), and their current views about the service. I have also asked for some basic background data as I find a few holes in my data set and it is simpler to ask everyone the same questions to ensure it is complete. Please feel free to make any comments about your experiences since leaving the , it would be great to learn how things are going for you.

I would be most grateful if you would complete the questionnaire and return it to me using the enclosed Freepost envelope. Please do NOT spend a long time contemplating your responses as I appreciate that you have much better things to do with your time (nevertheless, all essays will receive careful analysis!). Anonymity is assured by the coding system that I am using throughout my work.

If you do not wish to participate please return the form blank then I will know not to hassle you further.

Very many thanks for your help with this.

With all best wishes

Trudy Stevens
Researcher-Practitioner

APPENDIX 3: Letters to study participants.

Mr
Consultant Obstetrician

14 November 1994

Dear Mr

Evaluation of _____ Midwifery

I am a member of the research team evaluating _____ midwifery, with specific responsibility for the study of the organisational change.

As a part of this work, I am hoping to meet with all consultant obstetricians within the Trust during the next few weeks.

Appreciating how busy you are, I would be extremely grateful if you could spare me some time to discuss, in confidence, your personal perceptions of the development of this service. I will contact you shortly with the hope of arranging a mutually convenient time.

Thank you for your assistance with our evaluation.

Yours sincerely

Trudy Stevens
Research Associate

23 May 1997

To all Obstetric Registrars
Hospital

Dear

Re: The ethnographic study of

Midwifery Practice

As you may be aware, since 1994 I have been conducting a longitudinal ethnographic study of the implementation of Midwifery Practice. To-date much for the work has focused on data collected by interviews. However, I will shortly be undertaking some observational work, with the aim of gaining a greater understanding of some of issues raised by obstetricians and midwives during the interviews.

One of the areas that I will be focusing on is the ward round that is conducted on delivery unit each morning. My aim is to undertake a pilot study on one occasion to gain some idea of any difficulties that may be encountered, and then accompany the round over a two week period. It may be necessary to repeat this if the subsequent analysis indicates further work is required.

Consent from all staff involved will be obtained prior to undertaking this work. Although I am not observing clinical issues or care provision, as 'the round' enters the rooms of most couples on delivery unit their consent to my presence will also be obtained. If you are in-charge of the unit during this time I would be extremely grateful if you would allow me to accompany you on your round.

I aim to conduct the pilot study on Thursday 29th May, and the observation period will commence 2nd June for 2 weeks. If you have any queries about this work please do not hesitate to contact me. Messages left on extension 33522 or on my home number (0181 740 1106) should reach me if I cannot be immediately located.

With best wishes.

Yours sincerely

Trudy Stevens RM.RN.MA(Cantab.)MSc.
Researcher-Practitioner

d:/wrdmd.cnt

23 May 1997

To all Delivery Unit Midwives

Dear

Re: The ethnographic study of Midwifery Practice

As many of you are aware, since 1994 I have been conducting a longitudinal ethnographic study of the implementation of Midwifery Practice. Following the analysis of data collected from interviews, I will shortly be undertaking observational work of the ward round that is conducted in Hospital delivery unit each morning. This provides a classic and discrete example of an "interface" situation between obstetricians and midwives.

My aim is to undertake a pilot study on one occasion to gain some idea of the issues raised, and then accompany the round over a two week period. It may be necessary to repeat this if the subsequent analysis indicates further work is required.

Consent from all staff involved will be obtained prior to undertaking this work. Although I am not observing clinical issues or care provision, as 'the round' enters the rooms of most couples on delivery unit their consent to my presence will also be required. If you are on the unit during this time I would be extremely grateful if you would allow me to include you and the couple you are caring for in the study. On the relevant mornings I shall make my presence known to you prior to the round to obtain both your and your couples' consent. The couple will not personally be involved in my study and will not be disturbed by me in any way apart from my presence accompanying the doctors.

I aim to conduct the pilot study on Thursday 29th May, and the observation period will commence 2nd June for 2 weeks. If you have any queries about this work please do not hesitate to contact me. Messages left on extension 33522 or on my home number (0181 740 1106) should reach me if I cannot be immediately located.

With best wishes.

Yours sincerely

Trudy Stevens RM.RN.MA(Cantab.)MSc.
Researcher-Practitioner

d:/wrdmd.cnt

23 May 1997

To all Midwives

Dear

Re: The ethnographic study of Midwifery Practice

Following the analysis of the data collected from interviews, I will be undertaking observational work in two areas, both of which I would appreciate your assistance with.

The first area is observation of the ward round that is conducted in Hospital delivery unit each morning. This provides a classic and discrete example of an "interface" situation, both between obstetricians and midwives, and yourselves and the hospital system.

My aim is to first undertake a pilot run on one occasion to gain some idea of the issues raised, and then accompany the round over a two week period. It may be necessary to repeat this if the subsequent analysis indicates further work is required.

Consent from all staff involved will be obtained prior to undertaking this work. Although I am not observing clinical issues or care provision, as 'the round' enters the rooms of most couples on delivery unit their consent to my presence will also be required.

Although I sincerely hope this does not transpire, it is quite possible that no cases will be present on delivery unit during my period of observation; in which case I will obviously have to make alternative arrangements. However, if you are on the unit during this time I would be extremely grateful if you would allow me to include you and your couples in the study. On the relevant mornings I shall make my presence known to you prior to the round. I shall request that you obtain your couples' consent as I do not wish to disturb the atmosphere of the room unnecessarily. The couple will not personally be involved in my study and will not be disturbed by me in any way apart from my presence accompanying the doctors.

I aim to conduct the pilot study on Thursday 29th May, and the observation period will commence 2nd June for 2 weeks.

If you have any queries about this work please do not hesitate to contact me. Messages left on the 33522 no. or on my home number (0181 740 1106) should reach me if I cannot be immediately located.

d:/wntend.cat

The second area of study relates directly to yourselves and I hope you will be able to guide me as to how best to undertake the work. As you are aware, I worked with many of you at the implementation stage of the service. Subsequent to this I have focused on the hospital service, gaining an appreciation of the context in which the change has been introduced. The final part of the study is to gain an understanding of the nature of your work now that you have "ironed out" many of the implementation problems and become experienced in carrying a caseload practice.

I would like to carry out this work over the months of July and August. Please will you give some thought as to how best I can work with you. I am prepared to work at any time of day or night but my personal transport is limited to pedal power. Perhaps we can discuss the matter at your next monthly meeting when you will have had some time to consider my request.

With all best wishes

Trudy Stevens
Researcher-Practitioner



Name
Midwifery Practice

London

21 July 1997

Dear Name,

Re: Ethnographic Study of the Implementation of Midwifery Practice

As I highlighted to the group at your June monthly meeting, I would like to complete the data collection for this study by working with you all during the latter part of July and the month of August, focusing on Midwifery Practice now it is a more honed service.

The aim of this work will be to gain an understanding of Midwifery Practice from the perspectives of those currently delivering the service. Based on the analysis of my work to-date there are certain areas that I would like to explore with you, eg. identifying the current strengths and weaknesses of the service, how these may have changed, and why. Importantly, there may be certain perspectives that you feel need to be highlighted and made open to those who have not worked this way, particularly to those considering implementing and managing such services or working in this style of service.

I take this opportunity to reiterate that anonymity will be maintained throughout this work.

I hope you have been able to discuss my request within your individual group and to have formed some idea as to how you consider it would be appropriate for me to work with you. I have arranged with your group co-ordinator to join you at your next group meeting so we can discuss the issues in more depth at that time. I trust this will be acceptable to you.

With all best wishes

Trudy Stevens
Researcher-Practitioner

Midwife

13 August 1997

Dear

Re: Ethnographic Study of

Midwifery Practice

As the final part of this study, I would like to have two focus group meetings, one with midwives who have relatively recently started working in the scheme and the second with the remaining original group of midwives. This plan appeared acceptable to your colleagues when I discussed the idea at the monthly meeting last Friday.

As one of the remaining original members of the I would really appreciate it if you would join with the others so we can explore the development of the service since its implementation.

The group arranged that we all meet in house on 27th August, from 12.00 - 14.00 so we can have a relaxed and informal discussion. I will help to provide some lunch. This is an important meeting and I do hope that you will be able to come; please try to block the time out. It is an opportunity for you to share your views and experiences in a confidential way, and so help increase our understanding of what it is like to work this way, recognising the strengths and weaknesses of this form of practice.

With many thanks,

Trudy Stevens
Researcher-Practitioner

GLOSSARY

The definition of a midwife:

This is an extract from the definition of a midwife adopted by the International Confederation of Midwives (ICM) and the International Federation of Gynaecologists and Obstetricians (FIGO), in 1972 and 1973 respectively and later adopted by the World Health Organisation (WHO). The definition was amended by the ICM in 1990 and the amendment ratified by the FIGO and the WHO in 1991 and 1992 respectively.

'She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care included preventative measures, the detection of abnormal conditions in the mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units or in any other service'.

(Snmac Midwifery: delivering our future 1998 Standing Nursing and Midwifery Advisory Committee)

Terms

Antenatal (AN): Before birth, during pregnancy

Artificial rupture of membranes (ARM): Breaking the amniotic sac containing the fluid and baby. Usually a way to start or speed up labour (sometimes along with other methods).

Assisted delivery: Delivery of the baby vaginally using forceps or ventouse suction.

Breech presentation: The baby lying so the feet or bottom come first, rather than the head, as normal.

Booking visit: An antenatal contact early in pregnancy, when medical and midwifery services are arranged, including the intended place of delivery and type of care to be provided.

Caesarean section (C/S): Delivery of the baby by an abdominal operation.

Cardiotocograph (C.T.G.): see electronic foetal monitoring.

Community-led care: Care provided by mother's General Practitioner and midwives working in the community; hospital visits are kept to a minimum.

Continuity of care: All professionals involved share a common philosophy and way of working. The aim is to reduce conflicting advice experienced by women.

Continuity of carer: The same health professional(s) provide care throughout the childbearing episode.

Conventional care: In this study, care throughout the childbearing episode provided by hospital service or community midwifery service.

Domino scheme: Domiciliary In and Out, care during labour and delivery by community midwives, with an early discharge home.

Early discharge/transfer: Mother goes home from hospital 4 – 6hrs after delivery.

Electronic foetal monitoring: Monitoring the baby's heartbeat electronically, usually externally via a monitor held on the mother's abdomen, or internally using an electrode attached to the baby's head.

Epidural analgesia: A local anaesthetic injected into the epidural space around the spinal sac causing loss of sensation to the lower part of the body. 'Mobile' epidural involves particular drugs aiming to maintain mobility yet achieve pain relief.

Episiotomy: Surgical cut to the perineum to expedite delivery.

Forceps delivery: A vaginal delivery using forceps; a form of instrumental delivery.

Gestation: Length of pregnancy – usually calculated from the last menstrual period.

GP care: Antenatal care at GP surgery by GP/midwife; home or hospital birth +/- GP and community midwife, post natal care at home by GP and community midwife.

Hand-held notes: A mother's set of notes relating to the current childbearing episode which she keeps with her, to be used by any professionals that provide care.

Information stays with the mother, not stored in a hospital medical records department.

Home birth: Birth is planned to take place at home, supported by 2 midwives.

Independent Midwife: Self employed midwife, contracting with an NHS Trust or mother; providing part or all of care. Responsible to Local Supervisor of Midwives and required to notify intention to practice and adhere to UKKC policies.

Integrated care: Care is provided wherever appropriate, home, GP, surgery, hospital, not exclusively one place or person.

In utero: Within the uterus.

Induction of labour (induction): Starting labour artificially, using drugs and/or rupturing the membranes.

Lead professional: The professional who will give a substantial part of care personally and who is responsible for ensuring women have access to care from others as appropriate. Note – it not always used in this way as Obstetricians acting as LPs do not necessarily provide such care themselves.

Low risk/high risk: Women with no obvious physical, psychological or social problems, either before or during childbearing, 'uncomplicated', are considered 'low risk for complications. High risk is anyone not covered by this.

Meconium: Black tar-like stool passed by baby prior to delivery; may indicate the baby is distressed.

MIDIRS: Midwives Information and Resource Service. A registered charity specialising in dissemination of information relating to childbirth.

Midwife-led care: The midwife is the health professional who takes responsibility for planning and providing care, in the community or hospital, for mothers throughout their childbearing episode. Mothers may book directly with midwife.

Maternity Services Liaison Committee (MSLC): A local committee containing professional and lay representatives from maternity services. Roles vary widely.

Named midwife: Mothers are assigned to a particular midwife who is responsible for co-ordination of their care, even if it is not all provided by this midwife.

Neonatal: Referring to a newborn baby (up to 28 days old)

Neonatal unit: Hospital department providing specialist care for babies

Peer review: A discussion about practice, or an assessment of competence and skills by individuals, in groups of like-minded equals, with the aim of improving performance.

Perinatal: Around the period of birth.

Perineal: Area of pelvic floor between vagina and anus.

Postnatal (PN): Period of time after birth. Usually taken to be up to six weeks after the birth. Midwives' responsibilities continue for at least 10 days and up to 28 days after birth.

Prematurity (Prem): Baby born before 36 completed weeks gestation

Prolonged labour: A labour that continues beyond the accepted duration; may be considered dangerous to mother or baby.

Prostin: Drug used to try to start labour. Prostin induction.

Postpaturity: The baby has not been born after the due date has passed.

Shared care: Care is provided by GP and obstetricians.

Selective PN visiting: Until recently it was expected a midwife visit all women daily for 10 days and less frequently until 28th day. Now this is undertaken within this period according to an assessment of needs and wishes of the mother.

Start-to-finish scheme: Care is provided by an individual or small group of midwives who look after mothers throughout the childbirth episode, from booking to postnatal discharge.

Stillbirth: A baby which is born dead after 24 completed weeks of pregnancy.

Team midwifery: A defined group of midwives working closely to provide care for a specified group of mothers throughout their childbearing cycle; work in defined geographical area, in hospital and community community. The term may be used interchangeably with caseload midwifery.

Ultrasound scan: A procedure which uses sound waves to build up a 'picture' of the baby in the womb.

Ventouse delivery or vacuum extraction: A form of instrumental delivery in which the baby is delivered vaginally with the aid of suction applied via a shallow rubber cup fitted to the baby's head.

Woman-centred: The needs of women provide the focus for the planning, organisation and delivery of maternity services.

Definitions have been obtained from a variety of sources, including the Audit Commission Report, 1997, Green *et al*, 1998, and Leap and Hunter, 1993

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DECLARATION

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Stevens, T. A. and C. McCourt (2001). "One-to-One midwifery practice part 1: setting the scene." British Journal of Midwifery **9**(12): 736-740.

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Stevens, T. A. and C. McCourt (2002). "One-to-One midwifery practice part 3: meaning for midwives." British Journal of Midwifery **10**(2): 111-115.

Stevens, T. A. and C. McCourt (2002). "One-to-One midwifery practice part 4: sustaining the model." British Journal of Midwifery **10**(3): 174-179.

One-to-one midwifery practice part 1: setting the scene

By Trudy Stevens and Christine McCourt

ABSTRACT

Although proposing attractive women-centred services, the recommendations of *Changing Childbirth* (Department of Health, 1993) have been criticised for ignoring the needs of midwives who would staff them. Continuity of carer schemes place higher demands on midwives to be available for women; many doubted if they would be prepared or able to work this way. This is the first in a series of four articles reporting on a study of individual case load midwifery practice within an urban maternity service. The findings suggest that this model attracted midwives who, frustrated and disillusioned with conventional styles of practice, might otherwise have left the profession. After having mastered an initial 'steep learning curve', the midwives relaxed and reported immense satisfaction from working this way. They considered they were finally working as 'real midwives'. In this paper we define the model of practice and study details, 'setting the scene' for the subsequent papers which examine the nature and implications of individual case load midwifery for practitioners.

Trudy Stevens (pictured left) is a doctoral student at Thames Valley University, London and a practising midwife at Rosie Maternity Hospital, Cambridge. Christine McCourt (pictured right) is a senior lecturer in health services research at Thames Valley University, London.

This article was accepted for publication on 1 September 2000.



This is the first of a series of four articles drawing from a long term ethnographic study of the implementation of case load midwifery practice, a service development based on the recommendations of *Changing Childbirth* (Department of Health, 1993). In this article we outline the key organisational features of this model and detail how the research was undertaken. Analyses of the findings are presented in the subsequent papers which focus on the adaptations demanded, the meaning of case load practice for the midwives, and the sustainability of this service.

Background

In November 1995 an innovative midwifery project was implemented within a London NHS maternity service, aiming to cover almost 20% of its workload, i.e. 800 births per year. Two separate consultant-led maternity units were involved, each with different 'organisational cultures' (Wright, 1994) and approaches to care; the larger unit (4000 deliveries per year) had a strongly obstetric orientation and high levels of intervention, the small unit (1000 deliveries

per year) a more midwifery-orientated approach. Both units were internationally famous for medical research but neither had a history of midwifery development and research. The project was set up under the auspices of a newly established Midwifery Development Centre, a joint initiative of a local university and the maternity service.

Case load midwifery: the model

This service was designed to implement the *Changing Childbirth* principles of choice, continuity and control for women (Department of Health, 1993); the key organisational features are summarised in Figure 1. Each midwife was expected to carry a personal case load of 40 women per year and provided continuity of carer for both high- and low-risk women from pregnancy, through delivery and the postpartum period (National Childbirth Trust, 1995). Midwives planned and balanced their own case loads across the year, taking account of annual leave and suitable case mix. Women were offered the choice of midwife, GP or obstetric-led care provided in the home, GP surgery or hospital as appropriate. In practice, the majority of women defined as 'low-risk' had midwife-led or coordinated care, and routine visits were mainly at home.

Twenty midwives were employed to serve 800 women from a defined geographical neighbourhood. As over 50 GPs were

Figure 1. Organisation of case load midwifery

- 20 midwives working in partnerships, within groups of 6-8 individuals
- Each providing ante-, intra- and postpartum care
- A case load of 40 high- and low-risk clients per year
- Offering midwifery, GP or obstetric-led care
- Community- or hospital-based

involved, midwives were linked with particular surgeries for close liaison but were no longer 'GP attached' nor ran clinics in GPs' surgeries. Nevertheless, case loads were usually drawn from a local 'patch' that the midwives got to know well over time. Administration of the service was based from an office within one of the hospitals, where clerical support and supplies were available. However, the use of individual mobile phones enabled the midwives to work where and when required, rather than be tied to a specific place and time. Further details of the way the midwives managed their work is presented in the third article of this series, which addresses the meaning of case load practice for midwives.

The midwives worked in partnerships, initially set as one G grade and one F grade midwife, which were organised into groups of 6 or 8 individuals for the purpose of support and peer review. Coordination of the groups was shared on a rotational basis among the G grade midwives. Regular group meetings and close working relationships were an essential feature of the model and fortnightly peer reviews were an expectation of the project. The intended ethos of the service was to provide an environment in which skilled, sensitive and informed midwifery practice would flourish, to the benefit of both the women receiving care and the caregivers themselves.

This personal or partnership case load model was very different from team models (Flint, 1995; Wraight et al, 1995; Pankhurst et al, 1997; Green et al, 1998; Farqhar et al, 2000) or some group practice models (Allen et al, 1997) implemented following *Changing Childbirth* (Figure 2). The midwives were given a high degree of autonomy and flexibility in the management of their workload. Arrangements for being available to women on their case load were personal and varied but most organised this within their partnerships — for example, alternating nights and weekends or covering for short blocks of time.

The small number of visits demanded by a defined case load meant that midwives were able to reorganise their planned work and ensure rest time following night calls. Fundamental to this flexibility was the absence of fixed duties such as clinics and the acknowledgement that they were never used as a reserve workforce for the

Figure 2. Comparative organisational features of personal case load and team midwifery

Case load	Team
Personal or partnership case load: named primary midwife for each woman	Shared or team case load
Case load small and clearly defined	Case load often large and unpredictable
Expected to provide ante-, intra- and postpartum care	Expected to provide ante- and postnatal care; some intrapartum care
Continuity facilitates in-depth knowledge of each client	Unlikely to 'know' each client well
Personal responsibility and flexible organisation of work load	Team responsibility, some fixed organisation of workload
Location: woman-centred, no clear space defined	Location: in community, clinic or hospital defined
Self management of work and time	Fixed rotas — clinics, shifts, etc
Cover planned with partnership, then group, to personal preference	Fixed on-calls for shared case load
Unlikely to be called at night	Highly likely to be called at night
Known caller = visit only in emergency and labour	Little known caller = visit likely
Mobile phones	Individual pagers; mobile phone when on call
Do not get called into unit unless involves case load	Sometimes used as 'reserve workforce' — called in if unit extra busy
Minimum structure, maximum flexibility	Element of structure, limited flexibility

hospitals. An analysis of the midwives' work diaries (McCourt, 1998) showed that they worked an average of 6.6 'unsociable' hours a week although the mobile phone would be switched on for longer periods. A fixed salary enhancement was paid to cover the 'unsociable' hours work and this eliminated the need to complete timesheets.

Management and support

This service development was the first project of a newly established midwifery research and development centre and initially implemented as a 2 year pilot. With no precedence within the NBS and only the experience of independent midwives to draw from, the midwives were expected and supported in developing personal styles of practice that:

- Met the needs of their women
- Fulfilled a set of organisational targets, based on *Changing Childbirth* indicators (McCourt and Page, 1996; Page et al, 1999).

Apart from expectations concerning their dress code and mobile phone use, predetermined guidelines were not imposed but were



Case load midwives just after a home birth

developed by the midwives as required. They were actively supported in meeting whatever training needs they identified.

The project was initially overseen by an 'action group' of five senior midwives who met weekly and offered a 24 hour contact facility; this level of support proved unnecessary and was discontinued after 6 months. The action group included a project manager and a lecturer-practitioner, both of whom carried small case loads and supported those midwives who were unfamiliar with home deliveries.

When, after 2 years, the project was adopted as part of the mainstream service, official support was reduced to the lecturer-practitioner who supervised the student secondment and general management of the service while continuing to hold a personal case load. After a further 2 years this position was also discontinued and case load practice came fully within the remit of the main maternity service management.

Recruitment

Initially, midwives were recruited into the project from within the existing midwifery service. In view of the radical nature of the change, the emphasis of selection was as much on personal traits and attitudes as clinical experience; independence of

thought and practice were specifically sought although flexibility, adaptability and team spirit were also fundamental requirements. This resulted in positions being filled by midwives who were considerably less experienced clinically than many people outside of the project considered desirable. Nevertheless, 1 year post-registration experience was mandatory.

The mean age of midwives joining the scheme in 1995 was 32 years (range 24-43 years). This is a somewhat narrower age range than found among midwives nationally and younger than those typically working in community midwifery (Sandall, 1998). Mean length of experience since qualification at this point was 3.75 years (median 2 years, IQR 1.5-5.5 years) and 94% had less than 10 years experience, compared with 45% in Sandall's national sample (Sandall, 1998).

All were appointed internally, 5 from community midwifery, 17 from hospital wards. Eleven of the 16 subsequent joiners were recruited internally; their length of midwifery experience was similar on average (mean 3.75 years) but there were fewer with only 1-2 years experience (median 4 years, IQR 2-4.5 years). All of the original joiners had prior nursing qualifications, while one of the subsequent joiners had qualified via direct entry midwifery training.

Only one of the midwives had a dependent child under school age on joining the scheme. During the data collection period six midwives had children. Of these four returned or intended to return from maternity leave into case load midwifery, two into a job share position; three subsequently left. The other two intended to return to part-time hospital-based midwifery.

Project evaluation

As this project was implementing a new *Changing Childbirth* model of service, a robust evaluation was designed and undertaken with the assistance of an external committee of experienced researchers. This study included:

- Clinical audit
- Economic evaluation
- A study of women's views of care
- An ethnographic study of professionals' experiences and responses.

The initial evaluation of the scheme has been described elsewhere (McCourt and Page, 1996; Piercy et al, 1996; McCourt et al, 1998; Page et al, 1999). A follow-up study has been conducted to assess outcomes once the scheme was incorporated within the mainstream service (Page et al, 2001). Ethics approval was obtained from the relevant medical ethics committee. These articles are drawn from the ethnographic part of the evaluation which was undertaken by an external midwife-researcher with a background in anthropology.

The ethnographic case study: rationale and methods

The ethnographic study explored the implications this style of midwifery practice held for staff — both those carrying a case load and those working in the conventional service. Some issues were obvious, i.e. the requirement for the case load midwives to be available for extended periods, but others could be equally fundamental yet unrecognised. Gaining an understanding of the issues from the perspective of the staff involved was considered an important part of the evaluation.

As Stoecker (1991) has suggested, ethnography is particularly appropriate for studies that attempt to explain holistically the dynamics of a certain period of a particular social unit. The strength of this approach lies in its ability to deal with a variety of evidence and to understand it within its context. Rather than address pre-specified questions, the researcher is open and responsive to the perspectives of the people being studied, and uses flexible interactive interviewing and observation procedures to explore whether issues hold different significance for different people (Bryman, 1989).

As people's perceptions may be coloured by specific time-related incidents, and given that what they say may not be borne out in their subsequent actions, collecting a variety of data over a prolonged period of time is valuable in reducing such biases. For this study data were collected over a period of almost 4 years, from the implementation of the scheme in November 1995 until the end of August 1997. This extended period of time also enabled the processual aspect of the innovation to be considered, reflecting changes and adjustments over time as well as

Figure 3. Methods and participants

The data collection methods used were:

■ Unstructured and semi-structured in-depth interviews with:

- Midwives working with a case load
- A sample of community- and hospital-based midwives
- A sample of student midwives seconded to the case load project
- Maternity services and clinical directorate managers
- Medical staff (consultant, registrar, and house officers)

■ Focus group interviews with:

- Midwives who first joined the case load project
- Midwives who subsequently joined the project
- Hospital midwives
- Community midwives
- Student midwives seconded into case load practice

■ Participant observation of:

- Case load and community midwives' working practices
- Case load midwives' meetings, learning sessions, and peer reviews
- Hospital midwives' working practices on delivery unit
- Maternity services managers' meetings
- Student midwives' meetings

■ Questionnaires sent to all midwives who had undertaken case load practice

■ Documentary analysis of:

- Historical data from planning & implementation meetings
- Data collected for the unit and the directorate reports

simple patterns of relationships (Mitchell, 1985). *Figure 3* show the outline of the participants involved and data collected.

An understanding of the situation was enhanced by the constant presence of the researcher who lived on-site for much of the data collection period and also undertook some clinical practice to gain experiential knowledge of the local 'culture'. Perspectives gained in this way were then explored more thoroughly in formal data collection methods such as interviews.

All data were collected with the full consent of participants; interviews were tape-recorded where possible, transcripts anonymised and original records kept off-site. In recognition of the importance of the work to service development, perspectives gained were fed back where relevant during the course of the work e.g. by highlighting an issue of major concern to a particular group.

Analysis was undertaken using an open coding mechanism to identify emergent themes, in a process similar to grounded

theory analysis (Strauss and Corbin, 1990; Silverman, 1997). These themes are discussed in the articles to follow. Many of the ideas presented have been discussed with case load practitioners, both informally and through formal presentations and subsequent discussions. This has helped to control for researcher bias and check the validity of the analyses.

Conclusion

The material presented here comprises an outline of the service and the ethnographic study that formed part of the wider evaluation. It describes the model and its aims and has examined how these were operationalised in practice. Findings from the study in relation to the transition period, meaning of, and sustainability issues relating to case load midwifery practice will be presented in the subsequent three articles of this series. **END**

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KEY POINTS

- The intended aims of the service was to provide a supportive environment in which midwifery practice would flourish to the benefit of both mother and baby.
- The midwives had total responsibility and control over the organisation of their individual workload. This enabled them to work when, where and in a manner that was appropriate for their clients and for themselves.
- Analyses of the midwives' work diaries indicated they worked an average of 6.6 'unsocial' hour per week. Once experienced, they reported they were infrequently contacted at night.
- Case load practitioners were NOT used as a reserve workforce to be called when the service was busy.

One-to-one midwifery practice part 2: the transition period

By Trudy Stevens and Christine McCourt

This is the second in a series of four papers reporting an ethnographic study of the implementation of case load midwifery practice, a service development based on *Changing Childbirth* (Department of Health, 1995). The first article (Stevens and McCourt, 2001) described the background to the project and the study methodology. The meaning of case load practice and the sustainability of this model will be considered in the third and fourth articles, respectively. This paper draws from individual and focus group interviews with midwives who have moved from conventional hospital or community midwifery to case load practice. The adaptations demanded by such a change are explored. Key features of the model are summarised in *Figure 1*.

The adjustments demanded by case load midwifery, as identified in the analysis, are presented using the model of an iceberg (*Figure 2*). This illustrates the finding that, while several of the changes were highly visible and recognisable (first level), underlying them were changes of a more fundamental, long-term and perhaps less visible nature (second and deeper levels).

Although the issues identified were generally acknowledged, the changes encountered and adaptations demanded varied according to personal characteristics, expectations and experience. Nevertheless, this was an intense period of transition for all participants. It lasted approximately 10 months for the initial group of 20 midwives implementing the model, and 6 months for subsequent joiners, able to take guidance and advice from colleagues with experience.

First level: visible, tangible adjustments

Some immediate adaptations were obvious to everyone as being part of the job: case load midwives wore their own clothes and were required to practise all aspects of midwifery,

ABSTRACT

Drawing from the ethnographic part of the evaluation of case load midwifery (Mccourt and Page, 1996), this paper explores the adaptations and changes that were demanded from the responding midwives when they first held an individual case load. The participants reported that they needed time and experience to develop appropriate skills and approaches to the work. Some of the adaptations were obvious and expected, for example the movement away from an institutional setting and the requirement to develop skills in all areas of midwifery. Others, such as the importance of handling relationships with women (including 'educating women' as to reasonable expectations, and 'defining boundaries'), and of developing a flexible attitude to time and time management skills, became apparent over time.

in varying locations, according to the needs of the women on their case loads. These features form the tip of a metaphorical iceberg.

Uniform

The midwives elected by majority to wear their own clothes, following a debate about whether uniforms engendered a sense of security or of vulnerability in the community:

'It was very strange not being in uniform... we felt we needed that uniform for extra security or something.'

The group suggested that practice without uniforms enabled them to express their individuality and to be seen and related to as people. Hence the wearing of uniforms (or not) appeared to be connected with territory, status, roles and relationships.

Figure 1. Organisation of case load midwifery

- 20 midwives working in partnerships, within groups of 6-8 individuals
- Each providing ante-, intra- and postpartum care
- To 40 high- and low-risk clients per year
- Offering midwifery-, GP- or obstetric-led care
- In community or hospital

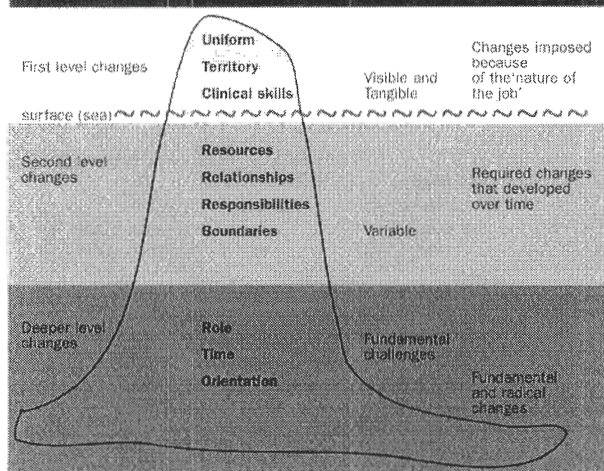
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CHANGING PRACTICE

Figure 2. The iceberg model of adaptations demanded by case load practice



Territory

The changes in territory were multidimensional in terms of place, time and organisation of work. In a hospital service the parameters of where, when and how midwives work are clear, with rotational placements, shifts and protocols offering minimal flexibility. In case load practice, the parameters are defined by the actual case load, not the institution, and were initially undefined.

Few participants had worked in the community, and several did not know the geography of the area in which they were working. Strangers in a strange locality, at first just getting to work was a daily problem for some:

“I was really scary in the beginning, I had barely driven...”

Even working within a more familiar hospital setting was not straightforward, as the service encompassed two maternity hospitals with a different ethos and different practices. The locus of control shifted wherever they worked; no longer ‘hosts’ within a maternity service, they became ‘guests’ within clients’ homes, GPs’ surgeries and hospitals. Some midwives reported difficulty in adapting to the freedom they felt once away from the structure of hospital routine. They felt guilty when not occupied and would seek out work.

“This week we haven’t been busy at all... I just felt bad, bad about the fact that I’m not working, well... you know, that I should be out there doing something... So what I find myself doing is coming to the hospital and looking up their results...”

Such need to ‘make busy’ has been described elsewhere (Melia, 1982; Menzies, 1989). Adapting to being available for women was central to the midwives’ management of their work. Learning to live with mobile phones, believing that they would inevitably be called and fearing that they would miss an important call were common causes for concern initially:

“The concept initially is one of “I will be called”. When you are new, you don’t realise that you probably won’t.”

It was important for the participants to learn how to relax unless they actually were called, and to switch off completely when they were not on duty when they were not ‘available’

Clinical adaptations

The ability to practise a more comprehensive style of midwifery was an important attraction, but was initially a source of anxiety:

“I was worried I would be able to work this way – not that I would not be able to work, but about the “what would I do if” issues.”

Case load practice demanded that each midwife be competent in all areas of practice, on a daily basis and with women with a wide range of needs and levels of risk. They were also required to be able to apply their practice in a variety of different settings, frequently isolated from colleagues. Different concerns were expressed by those who were experienced in hospital or community practice:

“I was petrified about looking after high-risk women, you know, Syntocinon and all that, I hadn’t got a clue.”

“The reverse for us was working in the home.”

The manner and speed in which this style of work developed their practice was highlighted by one midwife:

‘We had a learning curve that hit the roof; it was when I learned to be a midwife. In the hospital I didn’t know how, it was only when I went into the homes.’

Second level adjustments

The next layers in the iceberg included factors not so visible, their importance appreciated more as they developed over time.

Resource networks

In this pilot scheme, the knowledge and networks necessary for case load practice had to be developed. A variety of client needs within a diverse population were identified, challenging the midwives to establish a wide pool of useful knowledge to share with women and families.

The participants lost the colleague networks available in their previous roles, and experienced difficulties with access to basic resources once they were no longer attached to a particular department; so it was essential during the first 6 months to build new contacts with other professionals and agencies. The sharing of such knowledge, contacts and experiences became an important catalyst for cohesion within the case load group practices. Once established, information was passed on to subsequent midwives as part of their orientation into case load practice.

Relationships

The work of case load midwives required that they establish working relationships with a wide range of individuals. Three key categories of liaison were apparent: the partnership and group, with other professional colleagues, and with clients and families.

Partnership and group: Developing good working relationships within the practices proved essential. Successful partnerships were a source of great satisfaction and help over difficult periods, and the group practice became a major source of support which was increasingly appreciated with experience:

‘At first we tried to be independent, but it doesn’t work. You need to know where everyone is and who is off when.’

‘It’s (case load service) more like a big family than a department.’

Key elements identified by the midwives as helping to make a partnership work are presented in Figure 3.

Conversely, difficulties with relationships in these areas were extremely disruptive and stressful for both the individuals involved and the wider group. Resolving such tensions initially required support and assistance from management, but with experience the participants became more skilled in tackling group dynamics, recognising that ignoring problems could be destructive:

‘That’s not to say we haven’t had problems; we’ve had some group meetings where a lot of anger comes out, but that can restitute the situation.’

The group suggested that such skills are not readily developed within the conventional service, where avoidance mechanisms were more commonly used:

‘In the beginning it was difficult because you knew you had to get on, but in the hospital you know that if you have a row you don’t speak for months... Now you know you’ve got to sort it out.’

Professional colleagues: Successful working relationships with other professional colleagues required renegotiation, particularly in the early days when, as a new and high-profile scheme, the project generated some resentment among colleagues in the conventional service. There were initial difficulties in liaising with hospital-based midwives, and both case load midwives and the women they cared for reported feeling ignored by them. This declined over time, as acceptance and understanding of the model grew, but a few individuals remained opposed to the scheme. Nearly 4 years into the project new midwives still experienced difficulties:

Figure 3. Key elements in making a partnership work

- Communication
- Cooperation
- Mutual respect and trust
- Similar philosophy
- Shared methods and similar ways of working

‘The work of case load midwives required that they establish working relationships with a wide range of individuals.’

“In case load practice the midwife assumes clear and visible midwifery responsibility for a specific number of clients.”

“I’d go and hide in a corner and ring someone up on my phone.”

Carving out a new midwifery practice within a very medically dominated service caused some tension with the obstetric staff. For example, misunderstandings about the role of senior house officers in relation to that of the case load midwives produced some aggression on both sides. This attitude either developed into mutual respect, or remained as a difficulty that was acknowledged and aggression was superseded by assertiveness on the midwives’ part. A similar change was seen in the attitude of some GPs, initially upset by losing midwifery attachments or fearing loss of input into maternity care. Over time good working relationships developed with the majority of GPs. Occasionally, midwives perceived insurmountable problems in relationships with particular colleagues; then avoidance strategies came into play.

Women and families: In case load midwifery, prolonged contact and the assumption of responsibility for care encourages the development of a sustained relationship between midwife and client. Although acknowledged by all staff as an attraction of this style of practice, such relationships are not necessarily easy. Personality clashes or the client’s demands need careful handling, requiring interpersonal skills not necessarily used within the conventional service. Staff had to define and establish the types of relationship they felt comfortable with. Initially many tried providing total care, but soon realised that this may encourage dependency and learned to withdraw and share roles.

Responsibility

In case load practice the midwife assumes clear and visible midwifery responsibility for a specific number of clients. This generated a sense of pride and duty within the group, an attitude that is possibly an important safety feature. The responsibilities assumed were concerned with quality and appropriateness of care, which particularly challenged the participants when they had to determine whether a referral was required. Although managing referrals is a recognised responsibility of midwives, initial anxieties suggested that this was under-developed within the conventional service.

Responsibility for personal practice also involved knowing when to call for help. Initially, 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. This attitude noticeably differed with that of some hospital midwives who tended to deny or pass on responsibility to others, admitting that they might go off sick if their duty rota conflicted with social arrangements. Perceiving that they were not indispensable was an important lesson for the case load midwives.

Boundaries

Maintaining a balance between work and social life forced the midwives to define both professional and personal boundaries to themselves, their colleagues, and their clients.

Professional boundaries: Challenged by different situations, the group had to determine what the role of a midwife was, and was not, and to ensure that their clients’ expectations were appropriate.

“You have to learn your boundaries, how far you can go; that you are not a counsellor; a social worker or financial advisor; you need to learn when to refer people on, not just clinical, when to give them the responsibility.”

They also had to recognise clinical boundaries, not only when to refer, but also, how much they could influence outcomes:

“I have redefined my expectations of myself. If things went wrong in labour I used to think that it must be my fault and to be upset for them.”

The deeper relationships they developed with their clients caused the midwives to reassess their level of emotional involvement in the work. Learning to define boundaries and to say no was particularly hard with clients with difficulties:

“One woman wanted me to visit each week because she was lonely. Absolutely not! It may be hard to be firm but you have to... “You have to get over the idea that I’m not the answer to your problems”.”

Now it seems easier to do, we have all set parameters.

Personal boundaries: The participants also learned to outline personal boundaries. The requirement as a group to provide cover for clients 24 hours a day invariably intruded into their personal lives, the mobile phones proving to be both symbol and agent of this intrusion. Coming to terms, physically and psychologically, with more flexible working patterns was essential; so was learning to cope with the effect of being professionally available on their social lives and domestic arrangements. They needed to assess clearly and to define their expectations of the work and of themselves, to themselves and others:

If I had kept going as I did in the first year I would have burnt out within a year. Now it is much different.

When my phone is on I am a midwife, when it's off I am not. I don't look in my diary and don't check my phone for calls, I'm off.

The boundaries the midwives drew were highly individual and altered with different clients and with experience, ranging from a relatively tightly defined professional approach to a no-boundaries, totally open and involved style. Over time those with a tendency to the latter moved towards firmer boundaries, as they became aware of a need to limit their personal involvement.

Underlying adjustments

In undertaking case load practice the midwives had to face major adaptations that challenged their professional and personal roles. We suggest that in rising to these demands the participants experienced some fundamental changes, as identified in the bottom layers of the iceberg: changes in sense of role, orientation and time. These changes developed over a longer period and are discussed in the next article.

Discussion

This is a case study of an early pilot scheme, and it is helpful to distinguish between issues linked to change or innovation and those likely to be enduring features of the model.



Case load midwives at a postnatal visit

The difficulties encountered in settling into new roles are greater in a pilot scheme; however, such schemes tend to attract participants who are motivated or receptive towards change. Nonetheless, in this study similar issues arose for both the initial group of 20 volunteers and those who joined later, although the latter were able to draw on the knowledge of their partners and the group.

Students entering the service lacked the element of responsibility for case load and the control which enabled the midwives to make the job work for them; however, it is likely that if they returned to case load practice once qualified, they would then experience transition in a different way.

It is also important to bear in mind the context of this particular pilot scheme. Despite a great deal of information and consultation, there was some resentment and a perception of the group as an elite, adding to the difficulties of transition. The scheme was implemented within a strongly obstetrically oriented service, without experience of midwifery-led care and with high intervention rates and a limited community midwifery service. The intense scrutiny of research and the setting of organisational targets may have raised both expectations and fears of failure. Conversely, the philosophy of the midwifery unit was supportive and enabling rather than directive and controlling, encouraging an environment of learning rather than discipline (Handy, 1995; Curtis, 1994; Stapleton et al, 1998). While the issues discussed in this article are likely to be relevant to all midwives learn-

One-to-one midwifery practice part 3: meaning for midwives

By Trudy Stevens and Christine McCourt

This article looks at the experiences of midwives participating in a case load practice (CLP) scheme and what case load midwifery meant to them. Previous articles in this series described the service and the study, and the midwives' transition into CLP; the final article will consider the sustainability of the model. This article draws mainly from data obtained when the service had been running for more than 3 years. The midwives were reflecting on what was still a 'young' service development and those new to the practice were responding from the 'transition' period discussed in the previous article. Data were drawn from a questionnaire administered in July 1997 to all midwives who had worked in the service, from focus group interviews with the remaining original midwives and the newest recruits, and individual interviews held while working in and on leaving the service. The analysis was also informed by participant observation conducted as part of the overall ethnographic study.

Outline of care

In focusing on what case load midwifery meant to these practitioners it is important to understand something of how they worked in practice. The organisation and context of their work and the process of transition to CLP were outlined in previous articles and key features are summarised in Figure 1. In this section we describe something of the model as it was 'lived' and practised by the midwives, day to day.

Initially referred by their GP, self-referral by mothers to a known midwife became increasingly popular as the service became established. Referrals were coordinated within the group practices to ensure a balanced case load that fitted around planned leave. 'Reoffenders' as previous clients were nicknamed, were warmly welcomed and fitted in, in recognition that familiarity

ABSTRACT

This paper focuses on midwives' experiences of working with a case load and what it meant to them, both professionally and as individuals. Four themes emerged that summed up the midwives' experiences of working with a case load. These were role and time, holistic practice, relationships with women, and 'orientation' in relation to their sense of autonomy and responsibility. Midwives found case load practice rewarding in terms of control of their time, in their relationships with the women they looked after, and the personal and professional development they achieved. As a result, they felt like 'real midwives' in a way they had not done before.

with the woman and family and past history facilitated care provision that was then both easier and more enjoyable for the midwife as well as mother.

Partial bookings were usually conducted at home and followed by a hospital appointment for medical examination and dating scan. The timing and place of subsequent antenatal care was negotiated around women's needs and choice, with an emphasis on home visits as appropriate. Parent craft advice was offered during these visits although hospital-based and later community-based classes were also available. Women with complications received care from their midwife working in close consultation with an obstetrician. Women requiring hospitalisation received care from the hospital staff; nevertheless their 'own' midwife would visit and, in general undertake care such as inductions, with back-up support from the hospital-based staff.

As the midwives were 'available' to offer support and advice as required, they quick-

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Figure 1. Organisation of case load midwifery

- 20 midwives working in partnerships, within groups of 6-8 individuals
- Each providing ante-, intra- and postpartum care
- To 40 high- and low-risk clients per year
- Offering midwifery, GP- or obstetric-led care
- In community or hospital

Providing continuity of care was seen to hold particular benefits for the midwife, enabling care provision to be enjoyable and, by facilitating prompt feedback, informed.

ly appreciated the value of 'educating' their women about appropriate contact. Once this was established they reported that they were rarely called at night except for labour or an emergency: this is contrary to the commonly held perception that being 'on-call' invariably meant being called. Analysis of midwives' diaries indicated that they were called out for an average of 5.4 hours per week during 'unsocial' hours (McCourt, 1998a). Adaptation to such availability and the presence of the mobile phone formed an important feature of the transition period (see article 2). Most quickly learnt to adapt and, for some, their phone became an instrument of reassurance, enabling them to relax knowing their women could, and would, phone if they had a problem. Such comments echo those of women who reported being able to relax (and so often not call the midwife) in the knowledge that there was someone there for them if really needed (McCourt and Pearce, 2000).

Usually women phoned their midwife once they suspected labour had commenced. The midwives rapidly learnt to assess a situation over the phone, deciding whether it was more appropriate to visit the mother at home or meet her at hospital. With experience, they tended to care for more uncomplicated early labour in the home, moving to hospital once it was well established. As their confidence in home deliveries increased, the midwives talked about making the decision for actual place of birth during the labour, although this had not become established practice.

Initially aiming to provide intrapartum care for almost all of their case load, the midwives quickly recognised this was not sustainable and modified their practice by alternating nights and weekends when 'available' and ensuring their women were familiar with their midwifery partner (Beake et al, 1998). This also helped avoid the 'long hauls' which without support were exhausting, without compromising continuity or quality of care*. Awareness of each other's situation and requirement for support, relief or sustenance helped bind the midwives into a cohesive group. Consequently, partner and group support formed a crucial feature of CLP.

* In a follow-up study of the practice after the initial pilot period, continuity rates had remained similar (Page et al, 2001).

Nevertheless, although women were satisfied with care received from a known midwifery partner, it proved to be the case load midwife who appreciated being present at delivery and felt cheated if unable to be there:

"It's like revising for an examination and then missing the result. You have put all the hard work in... and then you don't know if what you have done has been appropriate."

Postnatal care while in hospital was provided by both hospital and case load midwives, a situation which initially generated some confusion and tension (McCourt et al, 1998). However, mothers were encouraged home as early as appropriate, and selective visiting was then undertaken by 'their' midwife. The midwives reported valuing the opportunity to review the labour and delivery with their women, discussing what had occurred as well as assessing treatment or advice given. Providing continuity of care was seen to hold particular benefits for the midwife, enabling care provision to be enjoyable and, by facilitating prompt feedback, informed. Such lessons were considered harder to achieve within the conventional service.

Reasons for joining

In focusing on what CLP meant to the midwives concerned it is important to consider why they originally joined this service. The reasons elicited by questionnaire are presented in *Table 1*; interview data suggested that the original midwives held slightly idealistic expectations while, with the advantage of other's experience, subsequent joiners had a realistic vision of the service. Nevertheless all responding midwives considered their objectives had been met. One midwife's response summarised the situation. Her reasons for joining were:

"Disillusioned with fragmented care in hospital settings. Frustration at not utilising all midwifery skills. Frustrations with the system of care not meeting women's needs. Institutional settings. Lethargic midwives entrapped in routinised practices."

When asked if her objectives had been met she said:

“Knowing women who I provide care for makes the job fulfilling and meaningful. I can follow pregnancies through and feel I am providing care which is more suited to the individual needs of women. Providing care largely in the community setting makes the job more interesting. Days are varied and to some extent unpredictable; it is never boring or drudgery.”

Frustration and disillusionment with the conventional services was also clearly identifiable in the interview data, with many midwives indicating that they were considering moving or even leaving midwifery had CLP not been implemented. This is suggestive that, although CLP may not appeal to all midwives, the profession may be losing strongly motivated individuals because of the predominance of conventional styles of service established since the 1970s.

The meaning of CLP for midwives

The experience and meaning of case load practise was strongly influenced by personal characteristics, past experiences and current social support mechanisms. However, from the evidence four key themes emerged.

Role and time

Individuality was recognised and supported initially by a management structure that encouraged the midwives to explore different patterns of working to ensure they made the job work for them as well as for the client. The midwives noted how they gradually learnt to appreciate and use, rather than ignore, the variety of life experiences their colleagues brought to the work. Contributing to their work as individuals more than just professionals was symbolised by the decision not to wear uniform, and they talked of:

“Actually being a person again, not just a cog in a wheel.”

“...you come out of a role.”

In the hospital service midwives assumed the role of a midwife during their shift, and reverted back to their roles of mother, part-

Table 1. Summary of reasons for joining

Original midwives (n= 18/20)	
■ Frustration with... leading to rejection of, conventional service, in particular:	
	Fragmentation — of service and care provision
	Lack of continuity
	Rota system
	Institutionalisation
	Colleague attitudes; poor motivation
■ Sought change, in particular:	
	Improved relationship with colleagues (medical and midwifery)
	Continuity of care
	Variety of work
	Promotion
	Autonomy
Subsequent midwives (n= 12/15)	
■ Experience of case load midwifery practice	
■ Increased job satisfaction	
■ Increased midwifery skills	
■ Personal development — autonomy, responsibility, challenge	
■ Continuity of caring	
■ Rejection of hospital routinised, depersonalised care	
1997 questionnaire responses	

ner or social actor for the remaining 16 hours of the day. There was minimal convergence of their professional and social roles. Conversely, midwives undertaking CLP had to develop a lifestyle that involved an incorporation rather than separation of these roles. This is at variance with the characteristics of industrial society where work and leisure, professional and personal, are frequently separated and time itself is both scheduled and commoditised. With moves towards flexible hours and home working arrangements this ‘traditional’ use of time is again coming to be seen as acceptable. Nevertheless, the midwives were working within the context of a society and a social institution where time is still highly compartmentalised and commodified (Frankenberg, 1992). The resulting tensions proved a source of stress.

However, the midwives described immense satisfaction from working this way, although they were keenly aware of the toll it took, particularly in the early days (see article 2). The ‘long hauls’, when called out for a birth after working all day, remained very firm and could represent an intrusion on their personal life. Nevertheless, these times were

Table 2. Personal and professional benefits from carrying a case load

Increased confidence (14/30 used this term) in:	
	All aspects of practice
	Own judgement, ability and skills
	Professional relationships
	Giving presentations
	General, particularly assertiveness
Midwifery development:	
	Increased knowledge and skills
	Experienced in all aspects of midwifery, in variety of settings
	Organisation of work and time management
	Communications skills
Greater understanding of:	
	Dynamics of a NHS Trust
	Personal practice (through reflection and peer review)
	Women's needs and family lifestyles
Relationships:	
	Interdisciplinary and with colleagues
Completing Studies (3):	
1997 questionnaire responses (n=30/35; 1 gave no response)	

balanced by the quiet periods when they were free to relax or to use their time in other ways. The authors noted that the midwives needed to learn to use this flexibility, to take the time that was theirs without guilt or making work, in order to achieve such a balance.

Holistic practice: developing all skills and impact on learning

Another theme involved the midwives' ability to practise a more 'holistic' form of midwifery than previously experienced. They valued the experience of delivering all aspects of care for both high- and low-risk pregnancies on a daily basis. Nevertheless, it was not merely the attainment of specific midwifery skills and research-based knowledge that was highlighted as important, but the application of these to meet the needs of individual women. Also, the continuous feedback received and opportunity to reflect on their practice proved central to their professional development. The midwives talked of at last being able to practice 'real midwifery'.

"This way of working teaches you what you know and what you don't know very quickly. It gives you the ability to consolidate your practice. You feel you are a midwife..."

This theme suggests that continuity of care may be multilevelled in its effects — it is not just about the woman's needs but about the coherence of the midwife's work and her ability to adopt reflective practice as well as facilitating learning from experience.

Relationship with the women

The relationships the midwives were able to form with their clients proved a major source of satisfaction to them, and was often quoted as an important reward of the job. Working with 'difficult' or demanding women proved particularly trying for the less experienced and achieving the right balance, to act as facilitator and enabler rather than inadvertently creating dependency, took time and skill to master (see article 2). Once an appropriate definition of relationship and boundaries was achieved, the continuity provided by CLP was the basis for a highly reciprocal relationship valued by mothers and midwives alike.

Orientation: autonomy and responsibility

The effect of such features of CLP changed the midwives' attitude towards their work, clients, colleagues, and the service. The issues central to the change in the midwives' orientation are ones of authority and control, involving management to midwives and midwives to women.

Through the analysis there emerged a clear sense of responsibility the midwives carried towards the women in their case load, towards their partnership and group, towards the project and the midwifery profession; although not towards the institution that employed them. This contrasted starkly with comments made by hospital-based midwives who showed a limited sense of an orientation towards women — for example, suggesting that if they were not there others would do the necessary work, a common feature of workers' roles in institutionalised systems (Goffman, 1968).

The variety of responsibilities involved in carrying a case load encouraged the midwives to develop in ways that were not honed by the conventional service. Ethnographic research shows how different hospital midwifery practice may be from midwifery self-concepts of independence (Kirkham, 1989; Hunt and Symonds, 1995). Many of the doctors developed a respect for the case load midwives, which they had not shown midwives before and which they described as recognition of the 'responsibility' and 'maturity' they demon-

strated, a change the original midwives also identified when reflecting back:

'You certainly found that if you have to do battle with the obstetricians they do talk to you, listen to what you say; they seem to respect you more.'

'Things that would have frightened me before, e.g. having to ring GP's surgery knowing that I'd be eaten over the phone by a GP or their receptionist... They haven't changed but I am not intimidated any more.'

In the questionnaire the midwives were asked to identify what they thought they had gained personally or professionally by carrying a case load: Table 2 presents a summary of their responses. Autonomy, expressed as a sense of freedom from previous confines, was an important aspect of what midwives described as a reward of the job. Combined with a sense of responsibility towards the women on their case load and for the outcomes of their practice, they felt this gave them the chance to establish what they saw as real midwifery.

Conclusion

It is clear from the analysis that the midwives' expectations of CLP were met and they found the practice immensely rewarding, in particular their relationships with women, their sense of professional development, and autonomy in managing their own work. As highlighted in article 2, there were real challenges in adapting to this role and the changes in time and personal orientation it engendered. In many ways, these challenges forced them to reassess and reconceptualise their role, but it produced strong perceptions of the meaning of being a midwife. In talking about being 'a real midwife' they referred to the value of psychosocial and woman-centred care, as well as the application of clinical skills. It was clear that the midwives saw continuity as important for the mother, but equally, as important for themselves in learning and developing their role.

What also emerges indirectly through their discussions of learning and developing through experience is the creative aspect of their work: the 'art' of applying knowledge

and skills that they saw as real midwifery. This included the involvement of 'self', the external expression of themselves and their internal emotions. It also entailed a sense of investment in their relationships with women that helped to produce developmental outcomes for themselves, and hopefully, the women as mothers. Their sense of personal involvement was demanding and challenging, particularly with the changes in orientation, role and use of time we have argued this implied, but it generated an enhanced sense of responsibility, independence, benefit and gain. Being given and able to take responsibility felt enabling and encouraged feelings of greater 'professionalism' (Sandall, 1996; McCourt, 1998b). We have noted, however, the clashes of this model with wider social structures and politics, in particular those of the employing institution, which presented challenges in adapting to such a role. **BJM**

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The variety of responsibilities involved in carrying a case load encouraged the midwives to develop in ways that were not honed by the conventional service.

KEY POINTS

- Once appropriately 'educated' women rarely called their midwife at night, except in an emergency or for labour.
- Continuity of caring proved a fundamental source of satisfaction for the midwives.
- Being present at the delivery was appreciated as much by the midwives as by the mothers.
- Carrying a case load was seen to develop the midwives, both personally and professionally, in a manner unmatched by conventional styles of practices.
- The fundamental adaptations necessitated by case load practice caused a major reorientation in the midwives' attitudes and a redefinition of the meaning of midwifery for them.

One-to-one midwifery practice part 4: sustaining the model

By Trudy Stevens and Christine McCourt

ABSTRACT

This article, the last in a series of four looking at the implementation of a case load (CL) midwifery scheme, examines issues around the sustainability of the model. It is based on a data collection period of 46 months, from the inception of the scheme following *Changing Childbirth* (Department of Health, 1993). The CL scheme now operates as part of the mainstream local service, and has recently been extended across the local community service. This article focuses mainly on problems and an analysis of the motivations of midwives who left, as the previous article looked at the meaning of CL midwifery and discussed the considerable rewards and satisfaction the midwives' experienced. Here we discuss the main factors in midwives' decisions to leave and how far these might be linked to the context of their work, the features of a pilot scheme or more enduring features of working with a personal CL.

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This article is the fourth in a series discussing key issues from an ethnographic study of midwives' experiences of case load midwifery practice (CLP). Previous articles have detailed the nature of the scheme and the study, characteristics of the case load (CL) midwives, the experience of transition to working with a personal CL, and the meaning of such practice to the midwives involved. This article focuses on the important questions concerning whether and how such innovative schemes can be sustained in the longer term. It draws mainly on interviews conducted with midwives on leaving the scheme ($n=12/15$ leavers) and questionnaires sent to all current or former CL midwives in August 1997: 22 current CL midwives (5 on maternity leave) and 8/15 leavers. The analysis was also informed by the overall ethnographic study.

Background

The expectation that working with a CL will mean high levels of stress for midwives have led a number of commentators to ask whether availability to women for birth is sufficiently important to women to warrant the demands placed upon midwives (Lee, 1997; Green et al, 1998). However, there is

limited evidence on the impact of personal CLs as opposed to team models (Wraight et al, 1993) on the midwives involved. Additionally, studies do not always differentiate large and small teams or consider the impact of context and ways in which different teams are organised.

A study by Allen et al (1997) suggested that midwives in 'group practice' experienced high levels of both job satisfaction and stress. However, it evaluated several different models, including individual CL and team-based approaches, with varying levels of control for the midwives over the size and composition of their CLs, the ways they organised their work and the other demands which might be placed on them. In the team midwifery scheme studied by Pankhurst (1997) midwives remained attached to GP surgeries, resulting in variable and unpredictable CLs. They could also be 'called in' to provide cover for the labour ward and to run clinics, in addition to the work of their own CLs.

Several evaluations suggest that team schemes may increase job stress for the midwives involved, although none have researched the impact on midwives substantively (Allen et al, 1997; Hart et al, 1999). Conversely, a number of studies have suggested that small team schemes may offer greater job satisfaction to midwives, through greater opportunities for personal responsibility, professional development and developing relationships with women which provide sources of satisfaction as well as learning from experience (Flint, 1995).

Sandall's study of job stress and burnout (1997) identified three key factors that made a positive difference to midwives: occupational autonomy, social support (both at home and at work) and ability to form meaningful relationships with women. She found that midwives working in teams lacked the sense of control over their work that contributed to job satisfaction and reduced stress. Both the midwives who carried a personal CL and community midwives reported lower levels of stress, although there were particular demands

associated with being 'available' to women, particularly for CL midwives. Bakker's (1996) study of Dutch midwives showed comparable findings.

Hunter (1999) drew on her oral history work with community midwives before the advent of the NHS (Leap and Hunter, 1995; Hunter, 1999) to look at their sources of job satisfaction and stress in relation to the key themes identified by Sandall (1997), concluding that occupational autonomy was a key issue. She found these midwives, despite carrying CLs which would be unacceptable today and working without the backup of a partner or group practice, gained immense satisfaction from the autonomy, sense of position in the community and relationships which were the stuff of their work. It is also important to note the wider context of midwifery work. Mackin and Sinclair (1999) in a study of midwives' experience of stress found generally high levels which were associated particularly with lack of control and autonomy, problems in interprofessional communication and too little time to perform duties to their own satisfaction. In contrast to Sandall's (1997) findings, and to the CL midwives discussed here (articles 2 and 3), they also saw the emotional demands of caring for labouring women as a source of stress.

The service

The midwives in this study carried personal CLs of 40 women of all risks per year, working within partnerships and group practices. They were given the authority to plan and balance their CLs and to organise the work, including providing availability to women, in the ways which worked best for them. The management style of the pilot scheme was facilitative, although they worked within an obstetrically oriented environment and a wider organisational culture with a different management style. Such contextual and organisational issues are important in interpreting the experiences of this group of midwives (McCourt, 1998).

The rates of 'turnover' of midwifery staff in this context (London teaching hospitals in an area of high mobility and housing cost) were generally high and, in line with national staffing problems, the rate of all midwives leaving increased during this period. Routinely collected data showed no clear

differences in midwifery turnover between the pilot and conventional services. Rates were higher in the final year of the pilot (1995), when seven midwives left during a 4-month period of uncertainty about renewal of their CL contracts, and were lower in subsequent years (1996-1997) than those for all midwives in this Trust.

During the data collection period of 46 months, a total of 15 midwives left the service (three were subsequent joiners, rather than those recruited to the pilot scheme). Of those who left, two remained with this Trust; four remained in clinical midwifery in other Trusts (three of whom took up higher graded positions); three undertook full-time studies in midwifery or health visiting; five left to travel overseas. One returned to the service, preferring CLP to a higher graded conventional post elsewhere.

Strengths and weaknesses of the service: summary of midwives' views

Tables 1 and 2 summarise respectively, the midwives' questionnaire responses on the positive and negative aspects of the service for themselves and its strengths and weaknesses overall. The midwives' positive views and their comments on strengths echo the authors' analysis of the meaning of CLP for the midwives (article 5): enabling the development of relationships with women and families and with other professionals, greater autonomy of practice, considerable professional and personal development, flexibility, variety and mutual support. These combined to give greater feelings of job satisfaction and a generally more positive view of midwifery.

Their views on weaknesses and difficulties highlighted problems relating to the local and the wider context of midwifery practice as well as the particular demands of carrying a CL. Table 2 shows that these midwives felt enabled to provide appropriate care for women in a manner which was satisfying for the practitioner, as well as facilitating well rounded professional development and politically and economically desirable service developments. However, they felt the demands the service put on the midwives were not appreciated by the senior management who oversaw the service once its project status had ceased.

Their views on weaknesses and difficulties highlighted problems relating to the local and the wider context of midwifery practice as well as the particular demands of carrying a CL.

CHANGING PRACTICE

Table 1. Summary of views about working in the one-to-one service

Positive points	Negative points
Current midwives (n=22)	
Relationship with women and their families	Attitudes of hospital staff; midwifery medical and management
Autonomy of practice — working independently, organising own work	On calls
Professional development — practising in all areas; obtaining feedback, opportunity to reflect on practice	Uncertainty about future of project
Continuity — both within pregnancy and between pregnancies	Demanding women
Group or peer support and shared philosophy	Long hours
Flexibility of working hours	Conditions of service (desire more pay and holiday, smaller case load; problems with lease cars and phone bills)
Job satisfaction	Inadequate staff cover or shortages
Variety; clinically and culturally	Colleague partnership problems
Working in community	Working over two hospital sites
'Being a person'	
Leavers (n=8)	
Standard and type of care provision; Able to offer high standard holistic care; Professional fulfilment	Poor support — poor backup when sickness; very busy, delays in filling vacancies
Relationship with colleagues	Interpersonal conflicts
Relationship with women	Hospital interface (attitudes of staff)
Job satisfaction	Intrusion of work into personal space and time
Questionnaire responses 1997	

Issues about feeling 'used' and unsupported and about inappropriate grading were common complaints, as were issues related to conventional services, i.e. lack of promotion opportunities or childcare facilities.

The following analysis discusses key themes that emerged from the interview and questionnaire data of midwives who left the service. The themes identified clustered into four areas: personal, professional, management and organisational and intra and interprofessional issues. In the lived experience of the midwives, such issues were not separate but closely intermingled so that concerns in one area impinged on or interacted with those in another.

Personal issues

Of the midwives interviewed (10/12) most cited personal issues as an important aspect of their choice, often the triggering factor in the decision to leave. These commonly included partner or family job changes and relocation, the desire to travel or to try something new. Several indicated that they felt

their work had created pressures for their partner. One, who had moved some distance from the local area, also cited childcare problems. As a primarily female workforce, with pay rates that remain relatively low, such issues are always likely to be important in retention of midwives. Another possible factor here is the characteristics of the midwives involved in a pilot scheme: they were primarily in their early 30s and had been selected partly on the basis of perceived openness to change (article 1):

'Working this way is very, very rewarding. This is midwifery.'

Researcher: 'And are you leaving it?'

'...I'm not leaving... I felt, yes, I am leaving... but the thing is — it's not that I'm (just) leaving work. I want a major change in my life at the moment.'

Professional issues

These were divided into 'positive' comments — such as the opportunity for promotion, further study or the desire for a new challenge — and difficulties with adaptation to this style of work. Only one midwife felt this style of work did not suit her personally, but several described similar problems in the adaptation period that were discussed in article 2. Most learnt strategies for making the work manageable, when to call for help and how to 'let go'. The challenges of transition, combined with the 'the initial proving period', in a professional environment where 'there was always something you had to be confrontational about', meant that if other issues subsequently arose, midwives were more likely to leave.

Management and organisational issues

These were also important, with several of the midwives citing lack of management or institutional support, feelings of not being valued, 'politics' and 'battles' around practice issues and the future of the scheme. They were reflected in failure to organise proper cover for long-term sickness or to plan ahead for maternity leave. When asked if this style of working feasible one midwife said:

'Yes, yes it is, if you have got the backup. If there is properly organised back up to cover sick leave.'

The initial management of the project had combined good support with a facilitative approach, but once the project was incorporated within the mainstream service, the midwives felt they lacked management to which they could turn for support. Continuing indecision about the future of the practice added to their general sense of uncertainty and of being undervalued:

'I don't know about rolling it out... We have never had a clear answer – that is the reason a lot of girls left.'

Reference to the general pattern of midwifery turnover in this period and comparable data on nursing suggests that feelings of lack of support were not confined to the CL midwives in this context (Borrill et al, 1998).

Intra and interprofessional issues

These were less commonly mentioned as specific reasons for leaving, although the midwives indicated they were an important aspect of the work, both a potential source of satisfaction and stress. Three midwives mentioned problems of lack of support within the partnership or group, confirming the importance of these arrangements for support and the need for managers to ensure means by which problems can be resolved:

'Lack of support and team work from partner. Lack of support from management about this. Working on my own.'

Problems in relationships with other professionals were discussed as general sources of stress and frustration rather than specific reasons to leave:

'Coping with medical and midwifery colleagues' anxieties as well as your own.'

But such issues clearly added to others to create a sense of tiredness or frustration for those involved.

Discussion

It was important for the validity of this study that the midwives felt able to be open and frank. Reflection and analysis of the data sug-

Table 2. Perceived strengths and weaknesses of the current service

Positive features	
For women:	Individualised, quality care for women and their families Continuity of care and carer
For midwives:	Fulfillment and job satisfaction Development of all skills Good peer support Valuable experience for students
For service:	Achieved goals of <i>Changing Childbirth</i> Coordinated multidisciplinary care meeting client needs and preventing duplication Motivated midwives
Negative features	
	Lack of support: limited resources Poor senior management support Relations (tensions) with hospital staff Cover with sick-leave Service limited therefore seen as elitist, (i.e. expansion desired) Lack of child care facilities for midwives Lack of promotion opportunities Practical issues (various cited) Service delivery over two hospitals
Questionnaire responses 1997	

gests that the midwives felt considerable trust in the researcher and perhaps used the confidential interviews as an opportunity to be frank and reflective in a relatively 'safe' way.

Only three of the midwives in this period had young children so that data on this issue were limited and difficult to generalise, although it was clear that good flexible childcare and support arrangements, or a partner with compatible work arrangements were important. Further research will need to address the needs of midwives with young children and the ways in which services can be organised to support them: for example, reduced or shared CLs.

It may be helpful, therefore, to consider the midwives who worked in the project as constituting two distinct groups: the first had to act as change agents, carving out a midwifery service from within a predominantly medical dominated service, the second needed to refine and consolidate the service delivery. Although characteristics of the original and subsequent joiners appeared similar (article 1) several of those who joined later cited initial concerns about the perceived (rather than actual) requirement to be 'constantly available' as a reason for tak-

Table 3. Key features: pilot, context or model of practice?

	Positives	Problems
Characteristics of a pilot	Challenge Excitement Newness Positive attention Involved in research and development	Working it out in practice Steep learning curve Uncertainty High expectations (self and others) Perceptions of elitism
Characteristics of the context	Profile and status Opportunities for personal development Escaping the confines of a medical ethos Escaping the confines of hospital practice	Interprofessional tensions Obstetric ethos and protocols No experience of midwife-led care or models Working on two sites Lack of wider management support
Likely characteristics of the model (learning and solvable problems)	Blurring of rigid work and leisure boundaries Flexibility Able to manage further learning Development of practice Developing networks Personal and professional development/advancement	Learning to manage less rigid boundaries Needs self/time management Risk encouraging dependency Risk of trying to 'do it all' Not knowing when to stop Guilt Feeling indispensable
Inherent characteristics of the model	Managing own work Relationships with women 'Being there' Autonomy Using all midwifery skills Continuity and feedback: learning from experience	Managing availability Regular 'on calls' Not wanting to miss births Responsibility Professional demands Need to be learnt from experience

ing a 'wait and see' approach. They took the opportunity to 'test out' the practice by undertaking maternity leave cover and all subsequently applied for, and were given, permanent positions within the service.

It was also clear that the issues are complex. Individual decisions, the relationships of midwives' experiences to the local, professional and institutional context of their work, as well as domestic arrangements and a social life were all involved. In CL midwifery these elements are symbiotic rather than exclusive, and many of the midwives left when their personal circumstances changed. These were the main catalysts but forthcoming change had caused them to reevaluate their situation.

Questions concerning sustainability of a service cannot be fully addressed by a study focusing on the initial years. Nonetheless, the authors suggest that this study has drawn out some general underlying issues that can be addressed in further research undertaken on different situations. *Table 3* models three issues especially related to working in innovative schemes and those issues more likely to be related to the model of practice and enduring across place and time.

Conclusions and implications for practice

Demanding a radically different attitude towards work, and in particular the use of time and a blurring of the work/leisure dichotomy, CLP is not necessarily suited to everyone or to all stages of an individual's career. With no previous experience to inform the 20 original midwives, and no opportunity to 'test it out'; invariably some might not have been able to adjust as they had hoped to the different lifestyle the work precipitated. However, only one of the original leavers indicated this view, with most citing a mix of personal, professional and situational motivations.

The rewards and stresses of the midwives' work may be considered in relation to the themes of occupational autonomy, support and relationships with women identified in Sandall's (1997) and others' work on job-stress and burnout (Bakker et al. 1996). This and previous articles have shown that the CL midwives obtained an enhanced sense of personal and professional autonomy. They felt more able to take responsibility and make decisions, to use all aspects of midwifery, in their words to practice 'real midwifery'.

They gained more professional recognition for doing so. They drew on the group practices as important sources of social support and on relationships with 'their' women and families that helped them to learn from experience and made the work feel worthwhile. Conversely, although they felt 'freed from the confines' of hospital practice, the 'cultural' environment of their work and the stunts of a pilot scheme limited the degree of autonomy they were able to exercise in practice and led to feelings of conflict and frustration.

Additionally, although the partnership and group could be important sources of support, relationships with other professionals in the

service and tensions resulting from the change were important sources of stress. Those midwives who also lacked a supportive relationship at home, or who were responsible for childcare with little domestic support, found the role more difficult to sustain. In a similar way, problems within partnerships or groups could undermine the individual's ability to manage her CL.

Since relationships with women were an important source of satisfaction, the authors also noted how important it was for the midwives to develop appropriate boundaries, to learn how to 'balance' their notions of support for women and not encourage dependency, in practice to develop the concept of the 'professional friend'. What was notable about their reflections on their experience was that they saw this practice as 'real midwifery' and expressed dismay at the possibility of having to return to conventional, particularly hospital-based, practice. The experience of this pilot scheme may provide lessons for others so that CLP may be developed as a sustainable model of practice for those who wish to work in this way and the many who might otherwise leave midwifery behind.

Pointers for practice

It is clear, even from this single case, that certain management and organisational arrangements are more likely to support this model than others.

What helps:

- Facilitative style — self management and responsibility but support, guidelines and help when needed
- Sense of control for the midwives, (e.g. use of their time)
- Flexibility of model (negotiation of on-calls within the partnership and group)
- Clarity around the nature and limits of their responsibility and lines for referral
- Appropriate support and induction structures for the transition (article 2)
- Proper cover planned in for long-term sickness and maternity leave
- Clear ground rules for partnerships and groups and flexible and agreed guidelines.

What doesn't:

- Scheme not well integrated with rest of service

- Ambivalence and uncertainty about the future — confusing messages
- Lack of communication and clarity around everyone's roles, responsibilities and contribution
- Conflict between medical and midwifery models (which may be brought to the surface by such a development)
- Management distance or, alternatively, 'too much' or 'heavy-handed' management. **BJM**

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KEY POINTS

■ Midwives found case load practice rewarding and satisfying. It enabled the development of satisfying relationships with women, families and other professionals, greater autonomy of practice, professional and personal development, flexibility, variety and mutual support.

■ There were a number of challenges and demands, i.e. the need to practice all aspects of midwifery, manage their own time and workload well and organise availability to women in ways compatible with their lifestyle. They had to develop appropriate boundaries and 'balance' their notions of support for women.

■ The main motivations those who left were personal. Other important factors were interprofessional problems, perceived lack of support within the institution and uncertainty about the future.

■ Participation in a pilot scheme and working in the obstetric context of a hospital with high intervention rates and no experience of midwife-led care was demanding.

■ Midwives saw this practice as 'real midwifery'.