

MIDWIFE TO MID WÍF
A Study of Caseload Midwifery

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This thesis is dedicated to Houwa Adam,
a foolhuma (traditional birth attendant) in
Ungoofaru, Raa Atoll, Republic of The Maldives,
who taught me 'mid wifery'.

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. A variety of data collection methods and analyses were used iteratively, in a process of responsive focusing. Reference to the literature was used to inform the understandings generated rather than the research focus. The prolonged study period facilitated a comprehension 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 different 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 by the conventional services, and which contributed towards a new form of professionalism for midwifery.

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.

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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?

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CONTENTS

ABSTRACT	i-ii
ACKNOWLEDGEMENTS	iii
CONTENTS	iv-vii
LIST OF TABLES AND FIGURES	viii
DERIVATION OF THE TERM MID WÍF	ix
CONVENTIONS USED IN THE TEXT	x
USE OF CODES	xi
PART ONE INTRODUCTION AND BACKGROUND	
Overview	1
Chapter One INTRODUCTION	2 – 14
THE STUDY	2
Seeking the Best Approach	5
Theoretical Considerations	7
STRUCTURE OF THE THESIS	9
CONCLUSION	14
Chapter Two THE HISTORICAL BACKGROUND	15 – 39
INTRODUCTION	15
FROM PRIVATE TO PUBLIC DOMAIN	16
The Movement from Family Control to State Responsibility	16
Attendants at Birth – from private to public service	21
THE INFLUENCE OF NEW TECHNOLOGY	29
A NEW APPROACH	35
CONCLUSION	38
PART TWO THE STUDY	
Overview	40
Chapter Three THE STUDY DESIGN	41 – 61
INTRODUCTION	41
AIMS AND RESEARCH QUESTIONS	41
STUDY DESIGN	42
ETHNOGRAPHY – SEEKING THE EMIC PERSPECTIVE	44
Construct or Reality – subjectivity in research	47
Practitioner-Research	48
Receptivity and Reciprocity	54
ETHICAL CONSIDERATIONS	56
Value	56
Access Approval	57
Field-Roles – the overt-covert dilemma for practitioner-researchers	57
Consent	58
Confidentiality	59
Professional Responsibilities	60
CONCLUSION	61
Chapter Four DATA COLLECTION AND ANALYSIS	62 – 89
INTRODUCTION	62
PARTICIPANTS	62
Midwives	62
Obstetricians	66

Managers	67
Others	68
Groups Not Approached	68
DATA COLLECTION METHODS	68
Ethnography as ‘Participant Observation’	70
Interviews	73
Survey Questionnaires	77
Focused Participant-Observation	78
Documents	81
DATA ANALYSES	81
Theoretical Focus	86
QUALITY OF THE STUDY	86
CONCLUSION	89

PART THREE THE MATERNITY SERVICE The Cultural Context

Overview	90
Chapter Five THE ORGANISATIONAL CONTEXT	92 – 112
INTRODUCTION	92
THE MATERNITY SERVICE MANAGEMENT	93
THE MATERNITY HOSPITAL	94
Staffing	95
Culture of Care	99
THE MATERNITY DEPARTMENT	105
Staffing	106
Culture of Care	107
THE COMMUNITY MIDWIFERY SERVICE	111
CONCLUSION	111
Chapter Six THE CASELOAD MIDWIFERY PROJECT	113 – 134
INTRODUCTION	113
CASELOAD MIDWIFERY – THE MODEL OF PRACTICE	114
PLANNING AND IMPLEMENTING THE PROJECT	118
Recruitment	121
The Start	123
CASELOAD MIDWIFERY IN PRACTICE	124
Student Midwives	128
SUBSEQUENT PROJECT HISTORY – THE CONTEXT OF CHANGE IS CHANGE	129
The Caseload Project History	131
THE EVALUATION	132
CONCLUSION	133
Chapter Seven THE PROFESSIONALS’ RESPONSE	135 – 162
INTRODUCTION	135
OVERALL PATTERN OF RESPONSE	135
THE MIDWIVES’ RESPONSES	137
Community Midwives	138
Discussion	142
Hospital Midwives	143
Discussion	152
THE OBSTETRICIANS’ RESPONSES	153
Discussion	156
CONCLUSION	161

PART FOUR CASELOAD MIDWIFERY PRACTICE

Overview	163
Chapter Eight BECOMING A CASELOAD MIDWIFE	164 – 189
INTRODUCTION	164
PROFILE OF THE MIDWIVES SELECTED	164
Motivations for Joining	167
Post Selection Preparation	171
LEARNING TO BECOME A CASELOAD MIDWIFE	171
Obvious Adjustments	172
Less Obvious Adjustments	175
Fundamental Changes	183
THE TRANSITION EXPERIENCE	183
' <i>Making the Job Work for You</i> '	186
CONCLUSION	188
Chapter Nine PRACTISING 'REAL MIDWIFERY'	
THE MEANING OF CASELOAD PRACTICE FOR MIDWIVES	190 – 211
INTRODUCTION	190
' <i>REAL MIDWIFERY</i> '	190
PROFESSIONAL ISSUES	191
Clinical Midwifery	191
Professional Relationships	197
RELATIONSHIPS WITH WOMEN	201
The Professional-Friend	202
The Professional	204
The ' <i>Demanding</i> ' Client	205
Avoiding Dependency	206
The Benefits of a Continuous Relationship	207
Terminating the Relationship	209
Issues Not Addressed	209
CONCLUSION	210
Chapter Ten PERSON NOT PERSONA	
THE INVOLVEMENT OF THE 'SELF' OF THE MIDWIFE	212 – 237
INTRODUCTION	212
INVOLVEMENT OF 'SELF'	213
Negotiating the 'Emotional Minefield'	214
INVESTMENT	219
RECIPROCITY	221
Reciprocity in the Literature	223
Reciprocity and Social Relations – changes in a service industry	225
The Significance of Reciprocity in Midwifery	233
CONCLUSION	236
Chapter Eleven POWER AND PROFESSIONALISM IN CASELOAD MIDWIFERY	
RE-DEFINING THE PARAMETERS	238 – 266
INTRODUCTION	238
THE CHANGING LOCUS OF POWER	238
The Appearance of Power	240
AUTONOMY	242
Autonomous, yet Controlled	243
Autonomy as Team-Work	246
KNOWLEDGE	247
Obstetrics as the 'Authoritative Knowledge'	247
Developing Caseload Knowledge – a new source of power	251
Trust	253

PROFESSIONALISATION OF THE OLDEST PROFESSION	254
The Ill-Fit of Traditional Models	254
Development of the 'Lay-Expert'	257
Caseload Midwifery – a new professionalism	259
Problem Areas for Midwives and Mothers	263
CONCLUSION	265
Chapter Twelve TIME – THE ULTIMATE CONTROL	267 – 290
INTRODUCTION	267
CONCEPTS OF TIME	267
USE OF TIME	270
Hospital Time	272
Time and Caseload Midwifery	278
TIME CLASHES	285
TIME AND RADICAL CHANGE	289
CONCLUSION	290
PART FIVE THE SUSTAINABILITY AND IMPLICATIONS OF CASELOAD MIDWIFERY	
Overview	291
Chapter Thirteen SUSTAINABILITY OF CASELOAD MIDWIFERY	292 – 314
INTRODUCTION	292
CASELOAD MIDWIVES' VIEWS OF THE MODEL	292
Why Midwives Left	294
CASELOAD MIDWIFERY AND ALTERNATIVE MODELS	299
Pilot Study or Honed Service	301
Minimal Change and Misleading Evaluations	304
THE VALUE OF CONTINUITY	305
The 'Known' Midwife – The 'Known' Mother	307
Continuity and Caseload Practice	309
CASELOAD MIDWIFERY – A SUSTAINABLE MODEL	311
CONCLUSION	314
Chapter Fourteen CONCLUSION AND IMPLICATIONS	315 – 332
INTRODUCTION	315
FROM MID WÍF TO MIDWIFE TO MID WÍF	
– THE CHANGING ROLE OF THE BIRTH ATTENDANT	316
The Significance of Mid Wifery	318
IMPLICATIONS FOR PRACTICE AND FOR SERVICE DEVELOPMENT	323
STRENGTH AND CHALLENGES OF THIS STUDY	329
FURTHER EXPLORATION – THE NEXT QUESTIONS	331
APPENDICES	333 – 352
Appendix 1 Ethics approval.	334
Appendix 2a Questionnaire sent to current caseload midwives.	335
Appendix 2b Addition to 2a for caseload midwives on maternity leave.	338
Appendix 2c Questionnaire sent to caseload midwives who had left.	340
Appendix 3 Samples of letters sent to study participants.	344
Appendix 4a Example of a 'Mind-map' exercise.	351
Appendix 4b Diagram of a sequence of the analysis.	352
CLARIFICATION OF TERMS	353
GLOSSARY	355
REFERENCES	358
PUBLISHED ARTICLES	383

LIST OF TABLES AND FIGURES

Table 1	The features of a technocratic model of childbirth	34
Table 2	Indicators of Success suggested by the EMG (DoH, 1993)	37
Table 3	Methods of data collection from participants	63
Table 4	Pattern of data collection methods during the study period	69
Table 5	Summary of delivery outcomes	99
Table 6	Principles of caseload practice	114
Table 7	Organisational features of caseload practice	115
Table 8	Organisational targets	116
Table 9	Uses and abuses - hospital midwives' complaints	148
Table 10	Age profile of caseload midwives on joining	165
Table 11	Year caseload midwives qualified	166
Table 12	Caseload midwives' midwifery experience prior to joining	167
Table 13	Reasons for Joining – Original Midwives	168
Table 14	Reasons for Joining – Subsequent Midwives	169
Table 15	Personal and professional benefits from carrying a caseload	222
Table 16	Knowledge development and the practitioner – structural and motivational features	249
Table 17	Alternative models of the social expert	262
Table 18	A comparison of orientations towards, and use of, time for midwives	279
Table 19	Perceived strengths and weaknesses of the current service	293
Table 20	Summary of midwives' views about working in the caseload service	293
Table 21	Number of 'original' midwives leaving by month of project	295
Figure 1	The iceberg model of adaptations demanded by caseload midwifery	172
Figure 2	Sources of satisfaction for caseload midwives	191
Figure 3a	Hospital-midwife–mother relationship	203
Figure 3b	Caseload-midwife–mother relationship	203
Figure 4	Economic exchange involved in the NHS health care system	228
Figure 5	Maslow's hierarchy of needs	230

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	Meydvyf	Midwife

1303 R.Brunne used the term "mydwyffe"
(Oxford English Dictionary 2nd ed 1989)

The definition of concepts central to this study is provided after the Appendices, in acknowledgement of the degree of confusion over their use in the literature.

A glossary is also provided for readers unfamiliar with terms used in this thesis.

CONVENTIONS USED IN THE TEXT

Two conventions have been adopted within this thesis.

The first is the use of the term 'mother'. This is used when referring to childbearing women to avoid confusion by the term 'woman' referring to either midwife or mother. It 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 to refer to childbearing women; 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.

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

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

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.

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

Category:

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 (Senior Registrar or Registrar)
	JO	junior officer (Senior House Officer)

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.

PART ONE

INTRODUCTION AND BACKGROUND

Overview

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 an ethnographic study of a group of midwives who, rejecting conventional ways of practising, worked with an individual caseload to provide continuity of care and carer throughout mothers' childbearing experiences.

Caseload midwifery is a radically different form of practice implemented within the National Health Service in response to a change in government policy. This policy reflected a philosophical, as well as practical, change in the nature of the maternity services. However, the implications inherent in such an alteration were unknown. Uncovering them, from the perspective of the professionals involved, formed the focus of this study.

An introduction to, and background for, this ethnography of caseload midwifery is presented in the two chapters that comprise Part One of this thesis.

Chapter One provides the introduction to the study. The focus and purpose of the research is outlined, the chosen approach justified, and the theoretical framework for the work described. The structure of the thesis is then presented with an explanation of the rationale behind this format.

Chapter Two situates this study of a radical change in the organisation of midwifery practice, within its historical context. This provides an understanding of why change was considered necessary. It is also the basis from which the significance of the implications of caseload midwifery identified may be fully appreciated.

Chapter One

INTRODUCTION

This chapter presents an introduction to this thesis by outlining the focus of the research and its relevance to midwifery and the maternity service. The theoretical framework of the study is detailed and the structure of the presentation outlined.

The thesis draws from an ethnographic study of the implementation of caseload midwifery, a model of practice designed to provide mothers with continuity of carer throughout their childbearing experience. The study focused on the implications for midwives of working this way. Commencing when they had just started and lasting nearly four years, both the initial problems and the features likely to be enduring to this model were identified.

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. The change was likely to hold ramifications for others working within the maternity service so identification of these was also sought.

THE STUDY

In November 1993 caseload midwifery practice was implemented as a pilot scheme within an inner-city, highly medicalised maternity service. Although renowned for medical research, this unit had no midwifery tradition of innovative practice or research. Caseload midwifery presented a very radical challenge to both the philosophy and practice of the service.

The development of the scheme had been stimulated by the House of Commons Select Committee review of the English maternity service (HoC 1992) and later, the report of the government's Expert Maternity Group, *Changing Childbirth* (DoH 1993). Both reports acknowledged and addressed the groundswell of dissatisfaction with maternity care that had developed over the preceding decades.

For the majority of women childbirth had become confined to hospital, ostensibly for reasons of safety. However, this had resulted in lack of choice, loss of control, and care provision by a number of relative strangers. It had also caused a major change in the position and role of the midwife. The majority of midwives now staffed particular departments within maternity hospitals, working under the close supervision of doctors. Although still legally practitioners in their own right, midwives had effectively lost their autonomy. Moreover, this situation encouraged a task orientation to their work as they became experts in defined areas, meeting the particular needs of many women rather than the wider needs of a few. The relationship that had once been achievable between a mother and the midwife, who was a known and trusted community figure, was lost. Both mothers and midwives had become objectified in a system that was highly institutionalised and medically dominated. Both were unhappy with this situation and delivery of care was recognised as being sub-optimal.

The model of caseload practice piloted encompassed key recommendations of the *Changing Childbirth* report (DoH 1993). Twenty midwives moved from the conventional service to each carry a 'caseload' of 40 mothers a year. Care was undertaken in the home, GP surgery or hospital as appropriate. As far as practically possible, the midwives provided continuity of care and carer throughout a mother's childbearing episode, from pregnancy, through birth to postnatal discharge at 10-28 days, when care was transferred to a Health Visitor.

A particular feature of this model was the inclusion of mothers with potentially complicated pregnancies in the caseloads (high as well as low 'risk' pregnancy and/or birth). By law midwives provide care for uncomplicated childbirth but are required to refer for medical supervision any deviation from 'normality'. The expectation that they would continue to provide midwifery care for mothers with complications effectively tied the midwives into the conventional system, albeit in a different position. This prevented the model, and midwives, from becoming completely isolated, separate from other parts of the maternity service.

Such a radical service development clearly held the potential for serious problems. It was not known if midwives could, or indeed would, work in this way. Practising under medical supervision might have resulted in such a degeneration of midwifery skills that the midwives were unable to exercise the autonomy and responsibility required. This could put mothers at risk. Also, the lack of structure to the midwives' working day, and the need to

be available throughout a 24-hour period, was considered a potential major personal problem for midwives. Given the dispute over junior doctor hours this development could be seen as anachronistic; the expectation that midwives would embrace working hours that others were campaigning to reject was questionable. Furthermore, working autonomously would alter the position of the caseload midwives within the institutional hierarchy. The potential for interpersonal conflicts arising between different groups of professionals was high, and the possibility that these might disrupt the maternity service recognised.

Such concerns were articulated within the development phase and an extensive evaluation was designed as part of the project. This was intended to both identify problems, thus facilitate remedial action, and 'test' the model to see if the expectations were met and if it was viable in terms of financial and human resources. A qualitative study focusing on the midwives and obstetricians, and their responses to the change, was included to address the personnel concerns detailed above. My appointment to undertake that study commenced the week the caseload project was implemented.

As an experienced midwife, yet relatively inexperienced researcher, I was both excited and concerned by the prospect of studying caseload midwifery. Acknowledging such a position is important as, unless accounted for, what is usually referred to as the 'baggage' of the researcher can influence the whole research process and undermine its credibility.

My excitement was raised by the prospect of such an innovative change within midwifery. I had practised as a midwife for seventeen years but, unhappy with midwifery in the UK, had spent nearly ten of these years working overseas in resource-poor countries. Periodic returns home had kept me clinically up-to-date and aware of the changes that were occurring. Most recently I had spent four years working with Traditional Birth Attendants (TBAs). New understandings about midwifery that I learnt from these elderly ladies, working alone and without viable medical backup, had caused me to seriously question service developments in the UK, particularly in terms of the social context of childbirth that now appeared subsumed by clinical concerns. *Changing Childbirth*, and so caseload practice, appeared to recognise these issues. It was an exciting development. Nevertheless, I had grave reservations.

My concerns lay in two areas: the viability of the model itself and the responsibility of undertaking research that held such potential for influencing the UK midwifery profession. In several ways the model of caseload midwifery to be implemented resembled that of the

TBAs I had lived and worked with, and the model apparently practised by midwives in England before childbirth became hospitalised (Leap and Hunter 1993). Both groups provided care for women throughout childbirth and this necessitated being available 24-hours per day. How viable was this expectation of English midwives in the 21st Century? The demands made on TBAs were relatively limited as they generally cared for only a few women (eg. 10-20 per year) and such work was embedded within the wider roles and responsibilities the TBAs held in their close-knit communities. In England, women's position in society had altered radically. Midwifery was no longer the vocational domain of the unmarried but undertaken by women whose expectations and responsibilities had expanded to encompass an active social life, essential income generation, and the roles of wife, mother and possibly parental carer. Moreover, the traditional support mechanism available within extended families and close knit communities had diminished with a general reduction in family size and increased geographical mobility of the population. Was caseload practice actually compatible with modern life?

My concern about undertaking the research related to 'getting it right'. This was an important development in midwifery and the consequences of the findings might have wide ramifications. The imposition, however unintended, of any positive or negative bias would skew the research – an important consideration in all research but holding particular significance in this instance. The model was effectively 'testing' government policy and decisions might be made in other maternity services on the basis of this work.

Seeking the Best Approach

The research was focusing on a social situation that was without precedence. As such it was an area informed by speculation, value judgements, competing ideologies and personal politics but minimal substantive knowledge. Some understanding was gained from independent midwifery, the model of care on which caseload practice was based. However, caseload practice was radically different on three accounts:

1. It was situated within, not parallel to, an NHS maternity service and so subject to the organisational constraints of this service. The ways in which the two might impact on each other were unknown.
2. Caseload midwives were to care for mothers experiencing either complicated or uncomplicated childbirth; this necessitated close liaison with the hospital based staff. The degree to which midwives and obstetricians could establish effective working relationships in such situations had yet to be determined.

3. The caseload midwives were to serve the needs of a very mixed population including very deprived women who generally lacked the financial resources necessary for an independent midwifery service. The implications of this, in terms of the possible demands made on the midwives, were unknown.

The subject area addressed was effectively 'virgin' territory and the implications for both individual professionals and the maternity service were yet to be determined.

The aim of the study, therefore, was to gain an understanding of what went on when caseload practice was implemented, and to identify the implications of this service development for all staff involved and the wider maternity service. The initial orientation of this work was practical in intent, seeking to inform service and policy development rather than sociological theory, although this was subsequently addressed.

A methodology was sought that would provide an understanding of the implications of caseload midwifery for all concerned. The individuality of particular experiences had to be recognised and the complexity of the social situation acknowledged, yet inferences needed to be drawn that were useful. The study was not merely an academic exercise designed to generate esoteric knowledge but was required to produce an understanding that held the potential for important practical applications.

An ethnographic approach was selected rather than action research as, although ownership by the participants might enhance the validity of the work, this could be at the expense of a degree of reliability. The study needed to encompass the views of potentially competing groups, all of whom already carried heavy workloads and were unlikely to appreciate the further burden entailed by action research. Also, these perspectives needed to be situated within the wider service context, entailing a dimension that might not be achievable by practitioners themselves. Ethnography, in contrast, was both epistemologically and practically suited to the demands of the work.

As a methodology, ethnography focuses on people's ordinary activities in naturally occurring settings. In seeking to explore the meanings their activities hold for those concerned, and the wider society, unstructured and flexible methods of data collection are used with the researcher actively participating in the society studied. This approach is premised on a philosophical position, the tenets of which are: the social world should be studied in its 'natural' state, as undisturbed as possible by the researcher or research tools;

it cannot be understood in terms of causal relationships or universal laws; and that diversity and complexity can be captured in detailed descriptions, not theoretical propositions (Brewer 2000; Hammersley and Atkinson 1995; Hammersley 1992).

This theoretical position does not assume that the world will look the same regardless of perspective, position or context. It offers an interpretative stance that challenges the positivist version of a model being the same regardless of situation. This acknowledges that particular findings may be a result of particular local features rather than enduring to the model. Moreover, it accommodates change and adaptation, allowing caseload midwifery to be understood as an evolving entity, responsive to a changing situation, rather than as a static model with predetermined criteria.

Theoretical Considerations

Ethnography was chosen to form the theoretical framework for the study and guide the data collection, analysis and subsequent representation. Nevertheless, in considering how the research would be conducted, the particular theoretical perspective to be employed had to be determined. The place theory should play in ethnography is strongly debated (Flick 2002; Brewer 2000; Hammersley 1992) and a number of different theoretical stances have developed. So called ‘nomothetic’ studies aim for the abstract generalisations and theoretical statements such as ‘interaction rituals’ and ‘frames’ of social behaviour suggested by Goffman’s symbolic interactionist approach (Goffman 1963, 1969, 1971) to the more distinct social theory developed through Garfinkel’s (1967) ethnomethodology. In contrast, ‘ideographic’ ethnography focuses on the individual, seeking to explore and describe people’s social meanings and lived experiences in their terms; theoretical inferences are thus limited although it is claimed that “*“thick description” itself leads to “theoretical description”*” (Brewer 2000:149).

The aim of this study was to develop an understanding of what went on and what it meant for midwives to carry a caseload, at a level that held significance for professionals, particularly those developing maternity care systems. The intention was not to test or generate ‘grand’ social theory, in a modernist sense of attempting to apply and extend a particular theoretical framework for explaining what is observed – eg. a ‘Marxist’ approach or a ‘functionalist approach’ – but to use theory, where indicated, to help make sense of what was occurring. Thus the study tended towards an ideographic approach that focused on the individuals that constituted particular groups, but moved beyond phenomenology by comparing the different groups and setting these in the general frame

of the wider maternity service. Such approaches have been considered as characteristic of post-modernism, being more tentative, provisional, contingent and referring to several 'middle range' theoretical areas (Flick 2002; Brewer 2000).

An open eclectic approach, as discussed by Hammersley and Atkinson (1995), Hammersley (1992) and Silverman (1985) was considered most appropriate in allowing the data to 'speak' for itself, unconstrained by any theoretical position apart from that determined by the ethnographic methodology. An inclusive approach, encouraging participation from all professionals, was adopted and a variety of data collection methods utilised over 46 months helped ensure as representative an understanding as possible was generated. Data collection and analysis were undertaken as part of an iterative process, each building on and 'testing' the other as an understanding emerged and was developed. Such understanding was repeatedly 'checked', both formally and informally, with the various participants as a means of confirming its trustworthiness.

The presentation of ethnography may be considered to represent the final analysis. It involves selection from the large amount of data gathered and variety of perspectives analysed. Clearly choices have to be made and much may need to be left for alternative publications. In the decisions made concerning this thesis I have adhered to the principle that guided this research: what was most important to the participants, in particular the caseload midwives? It is their voice I seek to represent, and to place this in a 'theoretical description' that enables their experiences to be of use to others. Thus the representation of their perspectives has not been framed in terms of a theory of change agency or oppressed groups, although the connections to such theories are noted. Such categories, though clearly relevant, were not as fundamental to these midwives as their reality of caseload practice enabling them to practice what they termed '*real midwifery*'. This, then, is the focus of this ethnography.

In seeking to uncover the meaning of their '*real midwifery*', issues of involvement of self of the midwife, of reciprocity, knowledge and power, and the 'control' of time are seen as central. No grand theoretical statements defining this new midwifery are proposed but this study offers theoretical descriptions of a new form of midwifery, or 'mid wifery' – being with women – and implications for this practice in post-modern society. In this study midwifery was seen to emerge from the confines of institutional care and a dominant medical hegemony. Although a very old tradition, midwifery is a new academic discipline and these findings will contribute to its growing body of knowledge. Their relevance will

be for those seeking to address dissatisfaction with conventional services, and those involved in the development of maternity care systems in countries where a medical hegemony is seen as the flag of modernity for childbirth services.

STRUCTURE OF THE THESIS

The material presented in this thesis is divided into 5 parts: introducing the thesis and addressing the historical background to the study; detailing the study design; describing the context in which caseload midwifery practice was implemented; presenting the analysis of the nature of caseload midwifery; and discussing the implications of these findings. These are detailed as follows.

Part One Introduction and Background

This initial chapter has outlined the focus of the research and the theoretical framework in which it has been situated. It also presents an overview of the structure within which the study and findings are presented.

The strength of ethnography lies in the depth of understanding that may be gained about a particular situation. Nevertheless, situations should not be considered in isolation, detached from their historical and wider context. It is only by understanding how things came to be that their significance are fully appreciated, and their relevance to a wider population understood. These perspectives are addressed in Chapter Two.

As this ethnography focuses on a radically different model of midwifery practice, implemented because of dissatisfaction with conventional maternity care, changes relating to childbirth in England during the past century are reviewed. Although implemented, ostensibly, to improve the care and safety of childbearing women, the unforeseen consequences of these changes have contributed to the alienation of both mothers and midwives from the experience of childbirth. Chapter Two details why the implementation of caseload midwifery was perceived as necessary and provides the background within which the significance of the findings may be understood.

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.

Part Two The Study

This focuses on the way in which the ethnography was operationalised in the study. Although considered the methodology of choice for this work, acknowledgement of the constraints and potential weaknesses of the approach, and details of how these issues were addressed, are presented. This allows the reader to make judgements concerning the trustworthiness of the findings and conclusions. Particular consideration is given to the position of practitioner–ethnography. The manner in which an ‘insider’ perspective contributed to the work, and the way the danger of inherent assumptions inadvertently distorting the data was guarded against, are discussed in Chapter Three. An understanding of how the data were collected, handled and analysed, and the quality of the research achieved, is presented in Chapter Four.

Part Three The Maternity Service – The Cultural Context

Comprising three chapters, Part Three provides an understanding of the context in which caseload midwifery was developed. This is important for several reasons.

Ethnography is concerned with understanding social situations, not the identification of universal laws such as cause and effect factors. It essentially involves presenting a descriptive analysis of what is occurring, what Geertz (1973) has termed a *‘thick description’*. Such an understanding of the situation studied facilitates comparison and application of the ‘findings’ elsewhere. Depth of description may also offer reassurance about the credibility of the research by facilitating a ‘face validity’ check that suggests it was not ‘all in the ethnographer’s mind’; this addresses the inherently subjective nature of ethnography. Thus a ‘thick description’ of the context is essential for the study to be useful, not just interesting.

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. This contrasts with positivist approaches which hold an inherent assumption that the model will be the same and generate the same effects

wherever or however practised – a drawback of many of the evaluations of new midwifery practices that have taken place.

Caseload midwifery practice cannot be divorced from the maternity service in which it was developed and managed. All the original caseload midwives were drawn from this service and many of them had trained there. An understanding of the organisation and culture of this service is essential for an appreciation of ‘where these midwives were coming from’ and what their experiences and orientation towards their work were likely to be, as well as the context in which this model of care was allowed to develop. It also provides the basis from which the theoretical considerations of the implications and significance of caseload midwifery, presented in Part Four, are drawn.

Firstly, an outline of the maternity service and the different organisational cultures it encompassed is described in Chapter Five. This offers an understanding of the ways in which midwifery practice may be controlled within a highly medicalised service. These perspectives are important for an understanding of the radical differences between conventional and caseload midwifery. They also help explain some of the difficulties experienced by the different groups during the initial years following implementation.

Clearly the model of practice designed, resources allocated to it and manner in which it was implemented frame the subsequent experiences of the caseload practitioners. Acknowledging this as a development within the wider Maternity Service these issues are addressed as Chapter Six.

Ethnography is useful for the uncovering of the views of all participants in the situation studied, valuing the less significant as well as those with power and authority. Although suggesting a separation away from the conventional service delivery, the model of caseload practice implemented did not promote midwifery isolationism but relied on effective team-work and co-operation. Thus the responses of the obstetric and midwifery professionals working in the conventional service to the innovation had a direct impact on caseload practice. These reactions and voices are presented in Chapter Seven.

Part Four Caseload Midwifery Practice

The nature and significance of caseload midwifery is addressed in Part Four. Initially presented as an analytical description of the experiences of the caseload practitioners

studied (Chapters Eight and Nine), theoretical analyses of the significance of these experiences are offered in Chapters Ten, Eleven and Twelve.

Although focusing on one particular social group, the value of ethnography lies in the degree to which they represent similar groups. This judgement, made by the reader, requires factual knowledge about the group; such data is presented at the beginning of Chapter Eight.

Drawing on the understanding of midwifery as practised within the conventional service (Chapter Five), the differences experienced when moving into caseload practice are the focus of Chapters Eight and Nine. 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 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 Eight. It is presented as a descriptive analysis of the transition period, highlighting both the obvious and less apparent demands made on the caseload midwives.

Despite the enormous change experienced, once they gained confidence the midwives found the work immensely satisfying. The sources of this satisfaction, relating to both professional and personal relationship issues, are explored and discussed in Chapter Nine.

The value of ethnography lies not just in the rich description of social situations but in an understanding of the significance of what is observed and how this might inform similar situations. In this analysis three key themes emerged as fundamental to caseload practice *per se*; each is addressed in the subsequent chapters. Firstly, the involvement of the 'self' of the midwife and development of reciprocity within their relationships with mothers. Caseload practitioners found their individuality was acknowledged rather than subsumed within a professional role. Also, the sense that they gained something back from their work emerged as an important feature of the midwife–client relationship. These features held potential benefits and disadvantages, both of which are explored in Chapter Ten.

Although designed to give mothers control over their childbearing experience, caseload practice offered the possibility for midwives to retain control. This was not observed in this

study. Instead a new form of power appeared to emerge for the midwives, one that involved partnership and mutuality between midwife and mother, and the development of new forms of knowledge for midwives. The way this may redefine the parameters of professionalism is considered in Chapter Eleven.

Sometimes considered an immutable and ‘universal’ phenomenon, concepts of time vary enormously and both frame and colour social interaction. The differing ways time was used and valued was seen as one of the major contrasts between caseload and conventional midwifery. The analysis presented in Chapter Twelve explores this theme and the concepts of time in medicine and maternity care generally. This offers an explanation for many of the difficulties encountered during the implementation as well as an understanding as to why caseload practice is not suited to all midwives.

Part Five The Sustainability and Implications of Caseload Midwifery

The final section considers these findings in relation to the development of midwifery services, addressing issues of sustainability and relevance.

Studies from other models of midwifery implemented in response to *Changing Childbirth* have suggested that continuity of care and carer schemes present particular difficulties to midwives and are not sustainable in the long term. These issues are addressed in Chapter Thirteen, first by considering why some caseload midwives left the project and then critically reviewing the literature with reference to the findings from this study. It is argued that pilot projects may motivate individuals who, attracted to change agency, seek challenges elsewhere once the project ‘settles down’. The studies reviewed examined a wide range of, often poorly defined, models of practice. These were essentially ‘teams’ and so lacked the autonomy seen here as central to successful caseload practice. They used research approaches that provided a relatively superficial understanding of what was occurring and, undertaken on relatively short-term pilot schemes, reflected a particular stage in the implementation of the model. 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. In using an ethnographic approach, a deeper understanding of what was occurring is achieved.

It has been argued that the development of caseload practice has caused midwifery to go ‘full circle’ and that caseload midwives are practising in a manner similar to that of their predecessors and in a way that is no longer compatible with the lifestyles of midwives

today. Such arguments are compelling as clearly the expectations and responsibilities of women have changed radically over time.

This study indicated that such movement may be considered more of a spiral than circle. Features of midwifery work that had been lost with the institutionalisation of childbirth did emerge as being regained and valued by the caseload practitioners. In particular the relationships formed with the mothers they cared for, having responsibility and control over their work, and gaining respect as a professional individual. Differences that contributed to the 'spiral' aspect, suggesting improvements on the 'traditional' model of practice, included: an organisational structure that ensured midwives did not work in isolation but as members of a team; a management philosophy that was supportive and enabling rather than controlling and judgmental; and technological developments that could enhance care provision, such as the use of mobile phones. Nevertheless, such differences could also have a seriously detrimental effect on caseload practice. Personality clashes might wreck effective teamwork, changes in the wider organisational management or ethos might conflict with that nurtured by the caseload team, and mobile phones could be perceived as dominating and controlling if not used effectively.

The implications of these findings for midwives and the maternity services are addressed in the concluding chapter and, it will be argued, are suggestive that for some midwives, given appropriate organisational conditions, caseload midwifery offers a highly sustainable model of practice.

CONCLUSION

This chapter has introduced the thesis by describing the background to the study and why it was undertaken. The theoretical frame of the work has been considered and a justification of the theoretical stance taken has been presented. The structure of the thesis, detailing the form, purpose and content of each section has been outlined.

The study has focused on a particular group of people, in a particular social setting, over a particular period of time. Nevertheless, the findings of this work cannot be fully understood unless considered in relation to the historical context in which it has been situated. This is reviewed in the next chapter.

Chapter Two

THE HISTORICAL BACKGROUND

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

INTRODUCTION

Maternity services are an integral part of society; concerned with its reproduction, they are also a reflection of its ideology. This thesis explores one aspect of these services: the way in which the organisation of midwifery work impacts on midwifery and care provision. In this study working with a caseload practice was seen to cause a fundamental change in midwives' orientation to their work and their profession. Their understanding about birth itself altered as relationships with the mothers they cared for flourished, and they reported that at last they were able to practice *'real midwifery'*. What they meant, and the differences between the ideology and reality of midwifery as experienced in conventional practice, can only be fully appreciated when understood within its historical social context.

This chapter presents this background by reviewing changes in childbirth that have occurred in England over the past century. Two hold particular significance. Firstly, a strong movement from private to public involvement has affected the domain of childbirth itself, and the regulation and employment of childbirth attendants. Crucially, this caused a spatial and psychological separation between mother and midwife, with unforeseen consequences. Secondly, technological advances have developed the fields of fertility, conception and childbirth, causing the moral and ethical norms held by society to be questioned. They also undermined intuitive knowledge of birth and generated a reliance on technology that both frames and controls what is now viewed as a process.

Both developments have had important effects on the experiences of childbearing women and their attendants, the midwives.

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. 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). 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 1910-20s, with medical care being recommended (Campbell 1923,1924). The general movement towards birthing in hospital also began at this time, with 15% hospital births in 1927 increasing to 54% by 1946 (Lewis 1990).

The reasons behind such a movement have been strongly debated but are likely to be complex and multifactorial. 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 (Beinart 1990; Lewis 1990; Hunt and Symonds 1995), although not all (Leap and Hunter 1993). The emergence of specialist medical care would have attracted some, although the degree to which such professionals dominated the arena is debated (Donnison 1977; Arney 1982; Oakley 1984; Loudon 1992). Nevertheless, the movement would have been facilitated by increased access through Local Authority provision, following the 1918 Maternity and Child Welfare Act and 1929 Local Government Act.

The post war years were a period of major changes in societal attitudes and state involvement. Attitudes to medical care may have been affected by notions of 'modernity' and the 'process of civilisation', as opposed to the 'savage' nature and pain of 'primitive' unassisted childbirth (Loudon 1992). An alternative, more 'natural' approach to childbirth gained some popularity during the 1940-50s with Grantley Dick-Read's psychological approach to relaxation (Kitzinger 1990). Nevertheless, increasing reliance on technology was apparent, and awareness was spreading of the development of spinal anaesthesia in America enabling painless childbirth (Hunt and Symonds 1995).

The assumed advantages of technology were also promoted in government policy. Increasing mortality figures after 1931 prompted an investigation (MoH 1937) which highlighted the clinical causes of death and also an inverse relationship with maternal economic circumstances (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). Hospitalisation of childbirth was considered the only way to avoid maternal deaths, although statistics indicated otherwise (Loudon 1992; Tew 1990). This was facilitated by 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 (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 and 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 reflected in the increasing popularity of books concerning childcare written by 'experts'. What was once considered intuitive knowledge was becoming 'professionalised'.

Maternity care at this time was becoming safer, with a reduction in maternal mortality rate resulting from pharmacological and clinical developments (Loudon 1992) and improvements in standards of living (McKeown 1976). Also, under the NHS access to care regardless of economic circumstances had been achieved. However, that care was now fragmented. Antenatal care could be provided by a General Practitioner (GP), 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. The involvement of the medical profession through the GP, was encouraged through the provision of a specific fee for GPs registered on the 'obstetric list'. 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, although little was actively done to address the situation.

Although the declared MoH policy for 50% hospital confinement had been exceeded, reaching 64% by 1952, both the Guillebaud (1956) and Cranbrook (1959) Committees continued to promote hospital birth, suggesting a target of 70%. The 1967 review by the Midwifery Advisory Committee (DHSS 1970), chaired by the obstetrician Sir John Peel, recommended facilities for 100% hospital births on the grounds that it afforded greater safety for mother and baby; grounds that were later challenged by a statistician (Tew 1985, 1990; Campbell and Macfarlane 1996).

The 1973 Reorganisation of the NHS Act, changed the management structure of the organisation but for mothers maternity care remained fragmented; antenatal, parentcraft and late postnatal care was provided by community midwives, 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). By the late 1970s the high perinatal mortality rate and a proposed decrease in maternity services funding in view of the falling birth rate prompted a further review.

The Social Services Committee report (1980) outlined 152 recommendations which promoted further medicalisation of childbirth: hospital deliveries were supported over home for reasons of assumed greater 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. In 1960 33.2% of births had occurred at home, by 1980 this had reduced to 1.2% (Macfarlane and 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 that they commanded can be appreciated in recognising that the 1960-70s 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; Kitzinger 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. 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, any effective consumer input, although variable, was severely restricted by a variety of factors and likely to have been minimal (Garcia and Garforth 1991).

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 that was perceived as uneconomic. The need to improve communication between professionals, and clarification of roles and responsibilities, was noted in policy 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. In the 1990 Act 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.

The domain of childbirth can be seen to have had radically changed over the past century, moving from a family centred activity to one effectively controlled by the state. This has had a major impact on the experience of childbearing for women and on the occupational status of those who cared for mothers at this time.

Attendants at Birth - from private to public service

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 domestic 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), *see* Chapter Eleven. 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 (Jordan 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 (De Vries 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 Dickens' 1843 portrayal of the lay-midwife, Sairey Gamp, 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 that 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 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, requiring a residential refresher course every five years and defining the Supervisor of Midwives' qualifications. By 1938, midwifery training had been divided into two parts, one year for nurses, two years for non-nurses and in 1946 midwifery training for State Enrolled Nurses was instigated, 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 service-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 not 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 and 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 mothers that they knew to birth, 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 24-hour service was undertaken in the manner devised for nursing; as the majority of midwives were by now 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 the 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 appears to imply 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. The implications of this revolution are explored here since such developments have fundamentally altered the needs, expectations and experiences of childbearing women and the working lives and expectations of midwives. Women's needs could be met by strong midwifery support. However, along with the hospitalisation of childbirth, such

developments have caused a further separation in any relationship between mother and midwife. Technology may be seen as having developed a life force of its own that frames the experience of childbirth and controls both mother and midwife.

The use of technology is not recent. Humans have always used technology in order to control and manipulate the natural world. World wide, many different forms of 'low' 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 wide spread, and as if the technology itself acts as a self-determining entity and controlling force in childbirth.

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 (Lock and Kaufert 1998). It also imposes hegemony on doctors that may be false, and belies the unease that 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. As previously noted, 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) was comparatively rapid, developing iteratively with its technology.

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. Technology enables, but it is the way it is used that generates the power for the benefit, or otherwise, of the hospital or the individual.

Technological developments clearly contributed towards minimising some of the dangers inherent in childbirth. However, the value of some interventions were simply assumed (Chalmers *et al* 1989) and could have iatrogenic effects (Illich 1975, 1976). Also of concern is the iterative process whereby one intervention leads to another being required to compensate for 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, that 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.

As with the hospitalisation of birth, the reasons are multidimensional and iterative. Giddens (1990) noted how 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, in the images depicted on television, powerful, speedy labours and glamour of doctors tend to replace the 'banality' of typical birth (Clement 1997). 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 increase reliance on technology.

Moreover, although offering reassurance, the use of technology may compound 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. Similarly, in their study of childbirth in the Netherlands, Pasveer and Akrich (2001) 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.

Of particular concern is the way technology was seen to have separated midwives from an appreciation of the physiology of birth, something this study indicated was redressed with caseload practice. Such separation has been clearly described in Davis-Floyd's (1992) description of the way American birth attendants used interventions to 'manage' labour and assess progress, denying any ability to birth on the mother's part. 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).

New technologies have 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.

Dangerously, a perception of omnipotence about technology appears to have evolved. The creation of a family is now individualistic, aiming to fulfil the hopes and desires of the parents and, although family size has reduced, expectations of perfection have raised (Giddens 1999). 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.

Nevertheless, rather than reassess and modify its use, this situation encouraged increased usage of the intervention (Davis-Floyd 1999); electronic foetal monitoring is the classic example of this (MIDIRS 1995; Page 1998; Walsh 1998).

If technological advances have established new expectations they have also created situations that require particular support. 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). Similarly, 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 the 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 1).

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, including those in this study, 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' (Jordan 1993, 1997) of childbirth; the knowledge that counts and on the basis of which decisions are made.

Table 1 The features of a technocratic model of childbirth

- 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 the machine, labour is the process, and baby is 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.

Source Davis-Floyd 1999

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 number of women are scarred by the process, either physically (Paranjothy and Thomas 2001a,b; Thomas and Paranjothy 2001; Page 2001) or mentally (Laing 2001; Robinson 2001).

At the end of the 20th century there is the suggestion of a 'post-modern' revolt against 'expert' systems (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). In this thesis, I will argue that caseload midwifery proved to be one of the mechanisms for enabling the balance to be redressed.

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)

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 number 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, reviewed the current maternity service in 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)

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, as previously, those relating to recognition of the influence of poverty on health that were likely to have a direct influence on maternal and child health (Mason 1995; Black *et al* 1988). However, an Expert Maternity Group (EMG) was established, with the aim of reviewing policy on NHS maternity care, particularly during childbirth, and to make recommendations. This group comprised 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. Underlying its recommendations was the principle of centring 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. This 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 (Table 2).

Table 2 Indicators of success suggested by the EMG

<ol style="list-style-type: none">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.

Source DoH 1993

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).

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.

CONCLUSION

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.

Change and development are supposedly synonymous with improvement. Nevertheless, in reviewing the changes relating to childbirth that have occurred in England during the last century, the ramifications of such 'improvements' become apparent, although all have been implemented to improve safety. Childbirth has become an institutionalised process, 'disembedded' from the society in which it occurs. Traditional mechanisms of support for mothers have been replaced by the expertise of professionals and much of the intuitive knowledge surrounding the physiological process of birth has been lost, subsumed by technology. The role of midwives, the so-called experts in normal birth, diminished with the hospitalisation of birth and adoption of a task orientation to their work.

However, I will argue in this thesis that this is not an inevitable process. Hospital birth is both appropriate and desired by many mothers; technology can hold enormous benefits if utilised wisely; and the role of midwives can be developed and enhanced in this modern climate. This study of caseload midwifery indicates how this can be facilitated through an organisational change that enables social relations, not technology, and the needs of the mother, not institution, to guide the work of midwives.

PART TWO

THE STUDY

Overview

This section of two chapters addresses the way in which the research was undertaken. In line with the fundamental reflexivity of ethnography it is presented in a reflective manner, to define both the intent and the experience of the work.

The first chapter considers the study design. The advantages of the approach used and the ways in which the disadvantages were tackled are discussed. Particular attention is paid to practitioner–ethnography as, although offering great benefits, such positions hold the potential for further increasing what many consider the main weakness of ethnography, subjectivity of the research. Ethical considerations of the study are also detailed.

The second chapter focuses on the data generation and analyses. The selection of and approach to participants is outlined, and the manner in which the data were collected, handled and analysed, described. Finally, the strategies used to ensure the quality of the research are summarised.

Chapter Three

THE STUDY DESIGN

INTRODUCTION

This chapter focuses on the design of the study. Both the aims and the research questions posed to address them are presented initially. The overall theoretical frame of the work, and the way this was interpreted, is then considered, with a particular focus on issues relating to the subjective nature of ethnography and practitioner–research. Finally, the ethical considerations of the study are discussed.

AIMS AND RESEARCH QUESTIONS

This study focused on the development of a radically different style of midwifery practice that had been implemented in response to the change in political thinking concerning maternity care, detailed in Chapter Two. The new policy was aimed at improving care delivery and the experience of childbirth for women. However, whilst giving women choice, continuity and control were espoused as the ideals, the significance this might hold for professionals was not known. The organisational and political changes required, and the tensions that might be generated, were acknowledged but not clarified. Also, the radical new form of practice promoted had obvious implications in terms of place, style and timing of work for midwives. Midwives' willingness and ability to work with a caseload were questioned, as were the effects this change in practice might have on those who continued to deliver the conventional style of care.

The aim of this study was to address 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. 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 issues considered of particular importance were the degree to which the findings were related to the particular study situation, and the identification of any difference between individuals' concerns and their subsequent experiences. These were addressed 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?
ie. what did individuals fear and what was their actual experience?**

STUDY DESIGN

The study was undertaken using an ethnographic approach which, as discussed in Chapter One, provided the theoretical frame that guided the research process.

The premise of this approach is that the social world, in this case a maternity service, is not a fixed and unchanging entity external to the individuals who participate in it, but is constructed and interpreted by those individuals. As people make sense of their world through this interpretation it cannot be understood by manipulation or testing of particular elements. Situations mean different things to different people so a social world comprises 'multiple realities'. Thus any understanding of a social setting needs to explore the perspectives of the participants.

The implications of this were that caseload midwifery could not be considered as a discrete model of care that would produce identical effects wherever replicated. It could only be understood in relation to the context in which it was situated and as interpreted by those who were participating in it. Knowledge about the context in which caseload midwifery operated could be gained from actively participating in it and by exploring the multiple

perspectives of the variety of individuals who formed it. Such perspectives would be accessed by listening to what people said and observing what they did, trying to understand their world in their terms rather than any predefined categories. This has been defined as seeking the 'emic', or 'insider' perspective.

The analysis of individuals' meanings from their standpoint indicated that the research should be undertaken with no pre-formulated theoretical propositions to confine the data collection or analysis. The study design and process needed to be flexible and responsive to the particular situation as an understanding evolved. Although exploring individuals' perceptions, to enable the movement away from the particular to a more general understanding, the analysis would involve the identification of commonalities that would then enable the induction of propositions concerning issues identified from the data.

Nevertheless, holding significance for a wider audience than the immediate maternity service, this study had particular issues to address relating to the effective delivery of a maternity service, not merely an understanding of the position of the various groups involved relative to each other. This was achieved by determining the emic perspective of each group identified and then the adoption of a comparative approach in which the different perspectives were considered in relation to each other and to the wider environment. The understanding generated is presented as theoretical descriptions and propositions rather than 'universal laws'.

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, participant observation and survey questionnaires.

- Understandings 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’ as opposed to ‘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 in addition to the ethnographic research. The ethnography was subsequently undertaken on a ‘part-time’ basis. Nevertheless, as my additional roles involved work within the study site this served to increase my understanding of the situation and proved advantageous in helping me become accepted by the staff. Also, by prolonging the duration of the study, this enabled an understanding of caseload midwifery practice beyond the implementation phase to be obtained.

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 – the ‘ethnography’ text (Agar 1980).

In the first edition of their seminal handbook, Hammersley and Atkinson (1983:1) noted disagreement amongst proponents of ethnography about its distinctive features. They highlighted 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). Such diversity in perspective and practice was embraced within their second edition where ethnography was interpreted in a liberal way, focusing on its use as a set of methods involving the participation and reflexivity of the researcher who seeks to make sense of the situation studied (Hammersley and Atkinson 1995).

Recently, the ethnography which has become popular within nursing studies, uses a more particularistic focus in addressing specific issues as a pragmatic response to limited resources and time constraints. Such ethnographies focus on a particular behavioural or belief area for study of its meaning among a specific group of people (Muecke 1994) than the broader sweep entailed in traditional extended fieldwork.

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 offered by Atkinson and Hammersley (1994) that featured:

- *'A strong emphasis on exploring the nature of particular social phenomena.*
 - *'Working primarily with "unstructured" data, ie. 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 1994:248)

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 ethnography, were considered appropriate to a study of a change in midwifery practice, in which the implications were unknown and were likely to be different for different people.

This 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 much as the 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 predetermined 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'. This enables an acknowledgement and subsequent exploration of any differences in what people say and are then seen to do. Such triangulation of data collection (Denzin 1978) helps strengthen the understanding gained by avoiding bias from time-specific incidents or particular individuals. It also helps to place the meanings of individuals into a context, a feature that distinguishes ethnography from approaches such as phenomenology. 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 is discussed in Chapter Four.

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' of the situation. Generalisations are made to typologies (ie. at a theoretical level) rather than populations 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*, and arguably the nature of conventional midwifery practice, that can be used to inform service developments elsewhere.

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 work 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'. Although the approach theoretically facilitated such an exploration, the position of the researcher required careful consideration in order to achieve the desired understanding.

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 and Biott 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.

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.

For practitioner–researchers such as myself, the advantage of familiarity with the study setting and community can prove helpful in achieving such fruitful relationships; however, it 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 has been considered essential; eg. 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. 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. 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 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 (1994:27) 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 1994:191). Quoting Naipaul in stating that:

'The only way we have of understanding another man's condition is through ourselves, our experiences and emotions' (Naipaul 1987:220)

Cohen (1994:190) 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.

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. It was important that I determined my personal position in relation to the work I was undertaking, identifying the strengths and weaknesses that I was bringing to the research. Conducting a 'personal construct exercise' early in the study to identify my thoughts and beliefs concerning midwifery work and maternity care, helped support and develop the reflexivity demanded by Cohen.

My experience as a practising midwife meant I was an 'insider' to the maternity services, familiar with the setting, jargon and expected behaviour. However, 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 (1995:9). 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.

As acknowledged in Chapter One, 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, from whom I had learnt a lot about 'midwifery', I was deeply concerned about the nature of 'midwifery' practised in England but questioned the consequences the new model held for midwives. 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. 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 initially 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 that 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 empathize 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 that 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

These are not separate activities in ethnography but build on each other. 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 a 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 one's 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:

- 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.
- 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.
- 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 the anthropologist involved with the wider 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 unsupportive of the study.

Hammersley and Atkinson (1995) 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, 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 identify biases that could 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, they appeared to welcome participation in the ethnography as this provided a channel to vent their feelings in a relatively safe manner. Also, they had accepted the challenge of caseload practice and it was important that their perspectives on the work were recognised. This part of the evaluation demonstrated concern for them as individuals, not just as 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. This view was counteracted by undertaking clinical practice within the hospitals, which facilitated adopting 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 was recognised that those closely involved with the implementation of the caseload project had an investment in the service development and might impose a particular slant on the situation. However, analysis of these interviews indicated 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

Hammersley and Atkinson's (1995) 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:

- Making oneself available at an unsocial hour and offering focused attention to an individual's views, demonstrated a respect for them personally, a situation not so frequently experienced by junior members of the health service staff.
- The interviews forced people to reflect on their situation and to consider issues in a way that their busy schedules often precluded. 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 provided an aid to the change process.

The realisation that the interview appeared particularly helpful to some of the respondents offered 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. Queries concerning general research issues, information, ideas for references or advice concerning questionnaires were responded to, often when undertaking clinical practice on the unit. 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

A number of important ethical issues arose during the course of this study which, given its potentially sensitive nature, required particular consideration. The way these were addressed are detailed below.

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. Evaluations of major changes in service delivery address the effects on care but rarely 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. The necessary support to undertake this work was made available.

Access Approval

Initially, ethics approval for the complete evaluation was sought and obtained from the hospital Research Ethics Committee (REC)(*see* Appendix 1). 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. 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 – the overt–covert dilemma for practitioner–researchers

When negotiating access to the research area, practitioner–researchers may be faced with an ethical dilemma as they define their field roles; how much of their practitioner background should they reveal? Individuals' response to the researcher will depend on the characteristics they ascribe to them, which then influences the data. Whilst the 'naive stance' recommended by Hammersley and Atkinson (1995) is difficult for experienced practitioners and deception offers little to relationships based on trust, some practitioner–researchers report being 'economical with the truth'. For example, Ersser (1996) found his

youthful appearance enabled him to avoid disclosure of his Tutor status when working as a Research Nurse. Alternatively, various aspects of one's biography may be emphasised, depending on the situation; Ersser found that to other practitioners 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. To the obstetricians an emphasis was placed on my academic background because of their tendency not to value midwifery research or accord it much status; to midwives I stressed 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, whilst acknowledging I was not on the unit in my research capacity, one sister called me to see the mess left by a caseload midwife. This undoubtedly worked to my advantage and such 'role swapping' was encouraged when instigated by the participants. 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 enabling people to confide as a friend rather than a researcher and still conducting ethical research was clearly apparent. 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 sought to make notes. If this was refused or it appeared inappropriate, what had been learnt could not be forgotten and such conversations were used as sensitisation to issues requiring future exploration.

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. 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). Nevertheless, however desirable, truly 'informed consent' was impossible to achieve. Many participants were not interested in full explanations but for those who were,

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) might have been more appropriate.

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 due to the number of people involved. The way this was negotiated is detailed in the discussion of each observation set (Chapter Four) but consent was always sought in a manner that facilitated refusal.

Although only a few women, and no member of staff, refused to participate, the pressure to be seen to be co-operative could influence behaviour. However, presence or absence from arranged focus group meetings, the 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.

Truly informed consent 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 considered critical as the potential for damage was very real; both the participant's and my own reputations were at stake. Absolute privacy during interviews was mandatory and tape-recordings were transcribed and stored off-site to avoid voice recognition. 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 restricted to myself as researcher and my university supervisors; material was presented in the 'public' arena only in a collated format.

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, 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 the data, permission was sought and given to name the study site.

Professional Responsibilities

Ethnographic research within one's own profession carries the potential for a conflict of responsibilities towards the research community and the professional body as well as the study participants. The witnessing of unacceptable clinical practice, and resulting conflict of

revelation and betrayal, never arose in this study, although the potential dilemma was recognised. As this study involved a change process aimed at improving client care, feedback was considered important. This was done on an informal basis as a member of the team overseeing the project evaluation; such interaction proved useful to the study as an understanding of the responses of the managers was developed. Caseload midwives were also involved in conference and seminar presentations, and their input 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, 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.

CONCLUSION

As will be understood from the preceding discussion, this study commenced with no pre-formulated theories influencing the expected findings. Exploratory in nature, the ethnography sought an understanding of caseload midwifery, 'what it was like' and 'what it meant' to all practitioners involved in the maternity service. Such perspectives could only be understood within the wider context of the environment in which it was situated, the maternity service. The ability to gain these insights was greatly enhanced by familiarity with maternity services and being a member of the professional community, albeit initially not the actual service studied. Although such a position holds potential for distorting the data, this was recognised and avoided or accounted for whilst maximising the advantages it held. The actual process of data collection forms the substance of the next chapter.

Chapter Four

DATA COLLECTION AND ANALYSIS

INTRODUCTION

This chapter focuses on the operationalisation of the ethnography. Whilst participation in the life of the hospital 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 from the perspectives of those involved. Details concerning the selection of the various participants and the manner in which data were collected, handled and analysed are outlined below.

For the purpose of explanation the different elements of the study are presented as discrete activities. Nevertheless, the participation, focused data collection episodes and analyses were all part of an iterative process in which ideas emerged and were explored and tested to finally generate the understandings that are presented in this thesis.

PARTICIPANTS

An ethnographic study undertaken in the 'natural setting' of a maternity service offered the potential involvement of a very large number of participants. Apart from the problems 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. For practical purposes choices had to be made about who to include and in what manner. Respondents were identified and invited to participate in the research in the following manner, summarised in Table 3.

Midwives

Four different groups of midwives working in the maternity service were identified according to their focus of practice: caseload, hospital, community and students.

Table 3: Methods of data collection from participants

Category	Data Collection Methods					Time Period
	Individual interviews	Focus Group Interviews	Observation of Practice	Questionnaires	Other Methods	
Midwives						
Caseload midwives	39: 28 participants 11 'exit' interviews	2 groups: 4 participants each group.	6 midwives: at 46, 46, 34, 26, 20, 2 months of experience with caseload	2: at 12 months & 45 months	Numerous observations of group meetings. Numerous informal chats.	November 1993 - end August 1997
Community midwives	1	1 group: 10 participants	3 midwives	1 to G grade midwives	Numerous informal chats with 1 participant. Informal chats with 6 others.	Spring 1995
Hospital midwives	9	3 groups: 3 participants, 2 participants, 5 participants.	11 sets of observation of Delivery Unit office and doctors' ward round.	1 to G grade midwives	Numerous chats during personal clinical practice.	FGI - AN Clinical June 1995 - Ward Jan. 1996 Ward Round D.U. June 1996
Student midwives	12	3 groups: 6, 7 & 8 participants.				1994; 1996-1997
Medical Staff						
Consultants	11					Nov. 1994 - Jan 1995
Registrars	5					June 1995
Senior House Officers	9					June 1995 & Jan. 1996 (3)
Managers						
Action Group	5 plus 2 'exit' interviews				Close participation in numerous meetings and daily work	November 1993 - end August 1997.
Midwifery managers	9 'informal' interviews					
Business Managers	2 plus 1 'exit' interview					

Caseload Midwives

As the focus of the study was caseload practice, an accurate understanding of the nature and range of the midwives' experiences, and of how things developed and changed over time, was required. All midwives who carried a caseload were invited to participate in a range of data collection methods:

- Initial individual interviews, exit interviews on leaving the project (28 midwives, 39 interviews).
- Focus group meeting of original midwives and of new midwives at 46 months (eight midwives).
- Baseline survey questionnaire at 12 months (20 midwives) and detailed questionnaire at 45 months (35 midwives).
- Observation of personal practice (six midwives).
- Participation in and observation of group meetings throughout the study duration.
- Informal contact. This was maintained throughout the period on a day-to-day basis as the midwives used facilities in the project corridor containing the research offices, and the hospital canteen. Informal meetings, eg. when making a coffee, helped establish a 'friendly and ever-present face' identity, facilitated by almost constant availability (7am–10pm). Such informal contact generated a quantity of important data.

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. However, it was recognised to be impractical and unnecessary to interview all midwives working in the hospital or department. In view of the larger number involved and the medical-orientation of their work presenting a greater contrast to caseload midwifery, midwives working in the larger maternity hospital were the main focus for formal data collection. The perspectives of the midwives working in the smaller maternity department were sought through working with them on the wards and through interviews with one sister and two E grade midwives (self-selected).

In the hospital, caseload practice and hospital practice interfaced in three separate areas: antenatal clinic, the wards and delivery unit. Midwives working in these areas were treated as specific groups and targeted separately, although it was recognised that staff rotated through all three departments. 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 initially 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. These were then considered unnecessary as midwives in the other two groups also talked about their experiences on delivery unit and an understanding of the situation, enhanced by personal experience, was gained from the many midwives who chatted freely whilst we worked together. The ethical dilemma this presented has been considered in Chapter Three. All midwives in both units were encouraged to talk 'formally' with me in my researcher capacity; three did so, interviews being arranged as two together and one alone.

Community Midwives

It was considered important to try and understand why very 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 with the one midwife who had been completely displaced from her local 'patch' by the caseload project (absent from the focus group).
- Three days participant observation of three community midwives – a self-selected 'convenience' sample reported by managers as not being particularly 'different' from their colleagues. Two had not been involved in the focus group meeting.

- 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 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 potentially very different perspectives. Initially, students were invited to individual interviews; however this proved difficult for them and the uptake was 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 these interviews 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 by both doctors and midwives. Ten such 'rounds', following one pilot observation, were studied.

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 as follows:

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 (39 months).
- 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 became involved in anything considered helpful to the research.

Other Managers

In the early days of the project I met with all the midwifery managers to explain the ethnographic research and seek their initial views on the project. 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. However, 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 the directorate participated as the senior obstetricians from both hospitals and as a member of the Action Group.

Others

A few individuals were approached in response to identified tensions. 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 within the obstetric physiotherapy and ultrasound scan departments when problems developed concerning referral from caseload midwives. Such meetings were more in the nature of 'clarification of issues' than ethnographic interviews although notes were taken with consent.

Groups Not Approached

The limited resources of one researcher meant that some groups who might have been affected by the development of caseload midwifery were not targeted during the study. These included the obstetric anaesthetists, paediatricians, hospital administrative staff such as ward clerks, and General Practitioners (50+ GPs worked in the area). 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

Central to ethnography is the use of a variety of data collection methods. This allows for a triangulation of perspective to be gained, minimising distortion by particular events or personal agenda. The following section details the methods used in the study and their interrelation to 'build a picture' of what was occurring. The overall pattern of data collection over the 46 months is summarised in Table 4. Participant observation was considered by Hammersley and Atkinson (1995) as a 'cognate' term for ethnography and, as indicated as the bottom section in Table 4, this was the basis of this study from which other forms of data collection were defined and undertaken as appropriate.

'Ethnography as 'Participant Observation'

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, then participant as observer to observer as participant and back. Gold's fourth type, covert observation, was not a feature.

During the 'working' day, implementation of the project and development of the evaluation generated a number of meetings, both formal and informal. 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 predominantly 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. Initially I was involved as an active participant in these meetings, later mainly as an observer.

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 with managers on my arrival, those undertaken to clarify specific issues, and discussions with individuals as they reacted to the daily events involving caseload midwifery. These meetings were not tape-recorded but notes were taken of particular issues that appeared significant at the time.

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 (1995) fieldwork, was facilitated by staying in the 'nurses' home'. This facility was 'home' for a number of hospital employees. Working in the project offices, situated on the ground floor of the nurses' home and near the hospital canteen, I 'lived' in the centre of the non-clinical life of the hospital, participating in it from early morning until late at night. This facilitated the establishment of informal relationships and sensitisation to what was 'going on', particularly issues that were of a more personal nature than the organisational ones which arose during the day. An additional advantage was that when I came to seek midwives' views through interview, I was able to build on established relationships and was aware of important issues to be explored in a defined way.

Serendipitous 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.

Reflective Clinical Practice

As the study sought to understand the implications of caseload practice from a variety of perspectives it was considered important for this to be perceived as more than rhetoric. However, as a member of the evaluation team I was clearly identified with the project and likely to be considered biased in favour of caseload practice by the other midwives. Working on the midwifery 'bank', and subsequently undertaking two clinical shifts per week, helped counter this perception and 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.

Regular duties were undertaken as an E grade midwife. This involved 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 readily merge 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'. There were a number of midwifery vacancies at this time and I found myself welcomed as a willing pair of hands on both units.

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

Such experiential understanding of the working of the maternity service was helpful in gaining insights into the environment in which caseload practice had been implemented.

Data Collection and Field-notes

Being immersed within the life of the study site proved immensely valuable in developing an understanding of the culture and sensitisation to certain issues. However, as Hammersley and Atkinson (1995) 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 1995) 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 people's reactions to these. Mindful of warnings concerning the danger of recording 'impressions', the concentration was on recording 'facts' and verbatim quotes (Spradley 1979). The initial generally broad remit of recording anything that seemed useful or different in some way became increasingly purposeful, focusing on issues considered relevant in response to the themes developing from the ethnography.

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, eg. insightful corridor chats, were noted on computer. No notes were made whilst working 'on-duty' but reflection on personal experiences and practice generated copious notes, made after completion of a shift. 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.

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.

To facilitate developing a group specific perspective, all interviews within each group were undertaken around the same time. The wider ethnography helped to contextualise this work, providing an understanding of any time-specific bias eg. particular events that influenced individual's perceptions. This 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 1995). 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, as befit the acknowledged hierarchy of the institution; more formal approaches were 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 throughout. Local pubs, restaurants and a health club were popular venues with midwives; 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 that did impact on 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, might 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 I was 'known' and, hopefully, 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 myself and the participant 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 myself, but there would be little empathy or emotion; it was more of an intellectual discussion about an issue. This contrasted with 'informal' interviews which occurred when 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' became apparent, as we both '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 individuals' 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 1995) 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 me 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, eg. the use of sarcasm. The value of tape-recordings when checking for researcher impact was highlighted in Chapter Three. 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 by a stranger.

Very occasionally participants chose not to have the conversation recorded (one consultant; two caseload midwives' exit interviews which were both held in a

restaurant). 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. A coding system was used to anonymise all interview transcripts.

Focus Group Interviews

Defined by Clark *et al* (1996:143) as '*simply a discussion in a small group of people under the guidance of a facilitator...talk about topics selected for investigation,*' focus group interviews were useful where the views of a larger group were sought. 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. Nevertheless, focus groups involve a more 'public' arena in which individuals are less likely to express 'deviant' views and the influence of dominant individuals needed controlling; as suggested by Fontana and Frey (1994), the skills of the interviewer as moderator were paramount.

In line with the advice of Kitzinger (1995) and others, group numbers were kept small (four–six participants) although were occasionally larger when circumstances rather than choice dictated. They were also undertaken within 'peer' groups, which is advised to reduce the feeling of being in a public arena and make people feel more comfortable to share views and experiences, even sensitive ones. 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 members.

A tape-recorder was considered not sensitive enough to record all participants clearly 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 advantages of easily eliciting the views of all members of a particular group with the safety of anonymity, enabling all views to be considered equally, and allowing issues to be prioritised by the participants. 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). This aimed to:

- Confirm and complete the socio-demographic data on the midwives.
- 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.
- Identify if, and how, they thought the service had helped them develop.
- 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 – a theme that had emerged in analysing the interviews. 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 by post with a covering letter. Although the letters were sent to named individuals, confidentiality was maintained by the questionnaires being coded. This mechanism enabled reminders (two) to be sent where necessary. Freepost envelopes addressed for the attention of the named researcher and labelled 'confidential' were included for midwives not currently working in the service.

The response rate was 19/20 (95%) for current practitioners, one was not returned by an individual who was leaving and had just completed a long 'exit' interview; 3/3 (100%) from those on maternity leave; and 8/12 (67%) from those who had left the project. Of the four who had left and did not return their questionnaire, one had stayed six months in the project and another was leaving the hospital service as the questionnaire was administered 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 participant-observations.

1 Community Midwives

Three 'sets' of observations were undertaken accompanying community midwives on their 'visits'. The aim was to gain an understanding of the way they worked, considering the advantages and constraints of this model for midwives (as opposed to mothers) and obtain their views about caseload practice. Each midwife volunteered to take me out; one had an accompanying student midwife. The purpose of the study was explained prior to the observation and midwives were requested to seek the mothers' informed consent for the presence of a researcher, where possible on the preceding day. The reality that this was achieved on some visits but not others appeared to reflect the individual midwife's attitude regarding authority and control. A degree of sensitivity was required to negotiate a form of consent I considered morally acceptable when the midwife 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 and further expanded once the visit was completed. Following each observation episode the notes were checked, 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.

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

2 The Obstetric Ward Round on Delivery Unit

The second 'set' of observations were made towards the end of the study period, focusing on a site of conflict of interest. Exploration of the issues was sought by undertaking observation of the obstetricians 'morning round' on delivery unit over 11 weekdays (one pilot plus ten studies).

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 was considered more ethical than a direct approach as they would have formed a relationship and an honest response might be more readily obtained.

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 commenced. 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 and I remained outside the door.

On completion of the 'round' both the senior participating obstetrician and the sister-in-charge were separately asked for comments. In particular, awareness of any deviations from normal was sought to enable valid judgements to be made about what had been observed. Notes were written up immediately afterwards to enable their expansion whilst memory was fresh.

3 Caseload Midwives' Practice

The third observation 'set' focused on the nature of the caseload midwives' practice as they experienced it. Undertaken towards the end of the data collection period this enabled the observation of both experienced and inexperienced caseload midwives to be made. Six sets were undertaken involving a partnership from each group. This was a self-selected convenience sample, 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. 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 use 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. Whilst acknowledging 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, directorate reports relating to caseload practice, JMC meeting minutes and delivery statistics were used as reference and clarification of specific issues as they emerged from other sources of data.

DATA ANALYSES

The aims of the data analyses were to generate an accurate representation of the perspectives of each group identified, to then consider these in respect to each other to develop an understanding of the dialectics involved in the inter-group relationships and differing perspectives, and finally to place these within a wider understanding of the maternity service. The intention was to obtain an understanding that was grounded in the practicalities of the professionals' experiences as opposed to any individual symbolic meanings that might be identifiable, a theoretical position outlined in Chapter One. The chronology of these 'stages' of analyses was more apparent in the design than reality, data collection and analysis proving an iterative process in which the understandings were developed and refined by progressive 'responsive focusing' (Guba and Lincoln 1989) rather than as a specific activity following data collection. However, following completion of data collection, the understandings generated were then further developed with reference to the literature, in an inductive approach aiming to inform and generate theory as opposed to testing it (Blaikie 1993).

A variety of different techniques for analysis were utilised in an interactive and iterative process, similar to that proposed by Huberman and Miles (1994) and Coffey and Atkinson (1996). These are described below. However, as with many ethnographies, the potential for generating an overwhelming amount of data was ever present and some selection regarding relevance was imperative. This formed an 'immediate' type of analysis in defining what to record and what to 'ignore'. The generation of a large

amount of data was a particular feature of the interviews, the participants apparently using this meeting as a relatively 'safe' form of 'sounding board'. It also reflected the initial inexperience of the researcher and the desire to encourage fruitful reflection. As the study progressed the interviews were increasingly focused in response to preliminary analysis and the need to explore particular issues, although participants were still encouraged in their reflections. This was considered important as a check for themes not yet identified and as a form of reciprocity for the participants.

Thus, recognising the iterative process of data collection and analysis, preliminary analysis commenced relatively early in the study. To avoid the potential danger of imposing a personal or etic frame of analysis and to remain open to the views of the participants, the interview transcripts formed the main focus and core of the initial work.

Analysis of Interview Transcripts

With the intention to seek an emic perspective from each separate group involved, their data sets 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 was undertaken first, during the early part 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 and Corbin (1990), was undertaken on a randomly selected half. 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 in relation to previously defined categories or where new and obviously important issues were raised. However, rereading and referring back to all the transcripts proved an important and integral part of the process of analysis, at all stages.

The 'exit interviews' undertaken when individuals 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 identification of new categories. They were also interrogated with a view to identifying reasons for leaving and if there were possible differences between these and the remaining midwives. These transcripts supported particularly rich and fruitful analyses, as they had provided the opportunity to

explore both issues that had become apparent during fieldwork and the 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 random proportion of the transcripts were coded in detail (generally half) and the remainder coded in less detail, in order to develop identified categories but remain open to the consideration of new issues.

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, as described by 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 the group, were likely to be of particular relevance to them. With this intention the coding and initial analyses had followed that prescribed for grounded theory analysis, as proposed by Strauss and Corbin (1990). However, when the perspectives of the individual group had been studied and specific themes identified, these were then developed by integration with other data sources, enabling the issues to be viewed from alternative perspectives and in a contextual frame.

These perspectives involved consideration of issues that were 'observer-identified' (Hammersley and Atkinson 1995), having 'emerged' as ideas and hunches generated from reflection whilst being immersed in the field and experiencing the practicalities of midwifery work in this maternity service. In recognition that some of these issues may not have been articulated during interview, the data were then interrogated addressing a

series of questions identified through a process of personal 'mind-mapping' drawing on knowledge of the study situation and the professional background (*see* Appendix 4a).

This involved, later in the analysis process, a gradual 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 serious 'hiccup' in the project became recognised as an important feature that 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 reported by the midwives 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' (*see* Appendix 4b).

Issues that had been identified as important from the analysis of the caseload midwives' transcripts were included in a questionnaire 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, to confirm the significance of issues previously identified and indicate their scope and strength.

Analysis of Questionnaires

As the numbers were relatively small, a simple content analysis of the two sets of questionnaires administered was undertaken. This involved collation 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 both validated and summarised the themes identified.

Analysis of 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 to 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 in a wider sense, offering new perspectives on themes previously identified elsewhere 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 eg. 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 read, clarified and stored for reference. As the study progressed the integrated process of data collection and analysis 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.

Theoretical Focus

The final level of analysis for this thesis was undertaken once data collection had been completed. The main core themes that had been identified were then developed with reference to the published literature, further data re-interrogation and reading being undertaken as different theoretical perspectives were refined. It was clear from this work that the data were particularly rich and would support development and analyses in a number of different theoretical directions. Choices had to be made as to the theoretical focus of this thesis. The nature of caseload 'midwifery', as understood from the themes that emerged as being fundamental to caseload practice, was selected.

QUALITY OF THE STUDY

Issues pertaining to the accuracy and value of the study have been embedded in Chapters Three and Four which address the manner in which the work was undertaken. However, it is perhaps helpful to consider these issues of quality more overtly.

The use of terms 'validity' and 'reliability' are considered to hold questionable relevance to ethnographic studies as they pertain to positivist epistemologies where universal laws are sought to define an external world (Hammersley 1992; Guba and Lincoln 1989; Brewer 2000). Their use in evaluating studies of social worlds comprising multiple meanings, proves difficult. Nevertheless, a relevance remains. Questions concerning the quality of such studies need to be addressed in whatever criteria considered appropriate, be it the broader issues of truth and relevance (Hammersley 1992) or examination of more specific issues such as trustworthiness, authenticity, credibility, transferability and confirmability (Guba and Lincoln 1989).

Two questions are therefore posed and the manner in which they were addressed detailed. Both questions relate to issues of quality, one concerning the data collection, analysis and representation, the other its possible value.

- Is this study an accurate representation of what caseload midwifery meant to the participants in the study?

- Does the understanding presented hold any relevance for situations apart from the immediate locality of the research?

The first question relates to the way the research was designed and undertaken; was it appropriate? Were the methods used suitable to provide the answers to the questions posed? Were there any internal or external factors that could have biased the data collection and so skewed the understandings generated? To what degree are the 'findings', and conclusions drawn, independent of accidental circumstances of the research? Issues that in positivist terms are concerned with the reliability and 'truth', or 'validity', of the work. Reassurance concerning these aspects is offered by acknowledgement of the following features of the study:

- Prolonged engagement in the field helped avoid a skew of time-specific events and enabled adaptations and alterations to be encompassed in refining the understanding generated. It also mitigated against particular participant bias, being a long time for individuals to 'put on a face' for the researcher or distort perspectives by personal agendas.
- An inclusive, as opposed to selective, approach to participants was adopted throughout the work. Key actors and small groups were identified and targeted individually; where larger numbers were involved wide participation was sought through focus group meetings and questionnaires; all participants in the study site were encouraged to meet with me individually to discuss caseload practice or the research if they so desired.
- Sufficient data: Guba and Lincoln (1989:237) used the term '*persistent observation*' when considering if enough data had been collected to add depth to the scope of the investigation that prolonged engagement affords, and to ensure identification of the most relevant characteristics of the situation studied. Such a concern was addressed by seeking 'saturation' in the data collection and analysis, developing the analysis only when no further new or deviant points emerged. It was also addressed by 'triangulation' or consideration of a phenomenon from a variety of 'angles'. In this study, such triangulation was achieved in a number of ways:
 1. Using a variety of data collections methods to help counteract the biases inherent in each.

2. Undertaking such data collection in different temporal and spatial situations, to counteract the bias of particular time-specific events or environments.
 3. Approaching a variety of participants, both within and external to each group identified.
 4. Developing the analyses with consideration to the wider evaluation. Although conducted separately, similar issues that were found to emerge from the perspectives of mothers receiving caseload care helped confirm those from the midwives (eg. concerning care provision on admission to wards).
- Constant feedback and testing of ideas was undertaken to enable a '*responsive focusing*' (Guba and Lincoln 1989:184), both during formal data collection episodes and in the informal meetings and conversations of daily life. This allowed an exploring of ideas and testing of emergent categories identified in the data.
 - Member checks on the developing analysis were facilitated as described above, through seminars about the research presented at local level, and by the specific involvement of caseload practitioners when presenting at national conferences.
 - Peer debriefing, in which individuals with no 'interest' in the study offer methodological challenges, was facilitated through the university where this and other postgraduate studies were registered.

The second question posed considers the relevance of this work to other situations. In alternative epistemologies this is considered as judgement concerning the 'external validity' or 'generalisability' of the study, how the knowledge gained may be used elsewhere. In ethnography, it is argued that the group and setting studied share certain essential characteristics with other groups and settings; the analysis aims to identify the central findings and develop a theoretical framework to explain what is going on. The provision of a 'thick description' enables the reader to make contact with the implicit and informal understandings held by those who are able to see parallels with the situation in which they work or have knowledge about (Hammersley and Atkinson 1995). Thus the key elements of inductive theorising and thick description of context are central to this ethnography but, as Guba and Lincoln (1989) noted, the responsibility for judgements over value are on the reader. Nevertheless, presentations of this work in public arenas have generated reports of a high 'face validity' as the findings 'ring true' with the personal experiences of practitioners working in similar schemes elsewhere.

CONCLUSION

This chapter has focused on the way the study design discussed in Chapter Three was operationalised. The choices made concerning the selection of participants to be approached and the manner in which the data were collected have been detailed, and the processes of data analysis described. Strategies utilised to minimise any potential skewing of the data collection and analysis process have also been highlighted.

As previously noted, for the understandings generated by this study to be fully appreciated and of value to the reader, knowledge of the context in which caseload midwifery was developed, and of the model itself, is required. These form the focus of the next part of this thesis.

PART THREE

THE MATERNITY SERVICE

The Cultural Context

Overview

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 their colleagues all influenced the nature of the practitioners' experiences.

The use of the term 'culture' in this context refers to *'the informal "concepts, attitudes and values" of the workforce'* (Wright 1994:2) 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 or homogenous, those features considered relevant to the experiences of the caseload midwives have been highlighted.

Following the ethnographic tenet of naturalism, this section details 'the picture' on which the subsequent analysis of caseload midwifery is based. Three chapters address the 'where?', 'what?' and 'how?' issues by providing a 'thick description' (Geertz 1973) of the organisational and professional 'context' in which this model of caseload midwifery was situated.

Chapter Five describes the 'environment' in which the development took place, detailing both the features and cultures of the organisations. This description of the maternity service illustrates the ways in which organisational features influence midwifery work. In one unit the medical hegemony is sustained through physical characteristics and midwifery compliance; in the second organisational changes introduced to improve continuity of care actually diminished this aspect, resulting in extreme fragmentation of work and poorly

managed wards. This chapter provides a detailed example of medicalised childbirth, as outlined in Chapter Two.

Chapter Six focuses on the model of caseload midwifery practice, and its philosophical and practical framework. Ethnography is frequently presented as a story, a device that enables the essence and chronology of the situation to be revealed. Although such a frame is not used for the complete thesis, it helps convey a sense of the tensions inherent in the planning and 'early days' and how caseload midwifery worked in practice. Change processes do not occur in a vacuum but in environments that are themselves changing. Uncertainty dominated the project and the wider maternity service throughout the study; both are acknowledged in an outline of the project's history. Finally, I will show that this study was located within a broader evaluation of different aspects of the scheme.

The reactions of the other midwives and obstetricians to the project and the caseload midwives are described in Chapter Seven as these both framed and influenced the experience of the caseload practitioners. As a radical departure from the conventional maternity service, the caseload project presented both an ideological and actual challenge to that service. For those continuing to work in the conventional way, it served to re-emphasise the difficulties they were experiencing. In this situation it is interesting that an even stronger resistance was not incurred, a reflection, perhaps, of the manner in which the project was planned and implemented.

Chapter Five

THE ORGANISATIONAL CONTEXT

INTRODUCTION

This chapter presents a ‘thick description’ (Geertz 1973) of the structure and culture of the organisation in which the caseload midwifery project was implemented. Building on this, it offers an understanding of what it was like to work as a midwife in this maternity service.

Such perspectives are important for several reasons. Firstly, they address the ‘naturalist’ approach of ethnography, recognising that processes of change are influenced by their context and may be experienced in different ways in different environments. This applies to the movement towards caseload practice, the subject of this study. The distinction between the adaptations demanded by caseload practice and the experience of these adaptations can only be appreciated with an understanding of the context in which they took place. As this was the setting where the caseload midwives had gained much, if not all, of their previous midwifery experience, this was the ‘baseline’ from which the majority ‘started’. Equally, the description indicates what it was these midwives were symbolically rejecting when they chose to undertake caseload practice. As such, it is also the basis from which much of the analysis is made when considering issues of self, power, and time for the midwife later in this thesis.

Finally, this description provides an illustration of the ways in which midwifery work can be affected by particular organisational constraints. The portrayal of frustrated and dissatisfied midwives presented in Chapter Two is ‘coloured in’ and offers an understanding of how a medical hegemony may be operationalised and maintained by midwives themselves (Kirkham 1989), and why some ‘Team Midwifery’ schemes can actually destroy what they were designed to enhance: continuity of care, and the carer (Sandall 1997).

Descriptions of both maternity units are presented, although a fuller analysis of the larger hospital is offered as, being dominant and supporting a medical hegemony, it enabled an example of a midwifery interface with the obstetric profession to be studied.

THE MATERNITY SERVICE MANAGEMENT

The caseload midwifery project was implemented 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 department'. They were very different and their unique situations and cultures are outlined and discussed below.

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). The Clinical Director, who was also the academic professor, was based at the general hospital with the smaller maternity department, 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.

Four consultant obstetricians were attached as O&G professors to the Royal Post-graduate Medical School (RPMS). 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 department 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. 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.

A hospital minibus shuttle was used by staff and for the transportation of laboratory specimens, equipment and post between the sites; the journey lasted approximately 20 minutes, depending on traffic conditions.

THE MATERNITY HOSPITAL

Originating as one of the early maternity hospitals 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 affluent clientele and, with a high-profile reputation, it attracted a considerable number of private patients from outside its catchment area.

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 that 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. Moreover, in what was otherwise a highly hierarchical organisation, it 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 due to personal ease as much 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. 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. 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

The Midwifery Staff

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 midwifery was subordinate 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 that 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), 10 F grade (1 PT), 53 E grade (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 recruitment and retention 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 posing 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)

A budget was available for staff training, and small awards were made through the 'Friends of the Hospital', however 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 at being unable to develop their midwifery knowledge and skills. Some reported they were 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)

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; although staff usually reported feeling too exhausted to go after 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 staff were found to be 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.hm.E12 &13.'96)

The warning to 'look out for yourself as they won't', received personally from an agency midwife, indicated 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' was experienced by some of the less experienced midwives. The term 'horizontal violence' has been used to describe how those excluded from power respond by directing their frustrations towards each other; such behaviour may be manifested as negative criticism, backbiting, hostility, undermining, sabotage etc. (Leap 1997).

Kirkham 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 (Kirkham 1999;

Freire 1972). 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 not due to lack of personnel.

Strong midwifery leadership was provided in the Midwifery Development Centre. However the professor's position was never clearly defined within the 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, 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. 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 usual source of information was 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 their 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 unit; subsequently little that occurred on the ward passed without their notice. Clinical care considered questionable was swiftly investigated and those concerned castigated. 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 5.

Table 5 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 unit provided a clear interface situation between the midwifery domain of 'normality' and the medical control of 'abnormality'. As tensions between caseload midwives and hospital staff arose at this point it proved an important focus for data collection. Analysis of such data offered a useful understanding of the culture as practised (Bourdieu 1977).

The delivery unit comprised 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 rooms, a four-bedded admission room, a three-bedded recovery/high dependency room and an 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. 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 rocking chairs, floor mats and bean bags were available for use during labour and rooms were equipped with telephones 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 opposing 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 unit 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 unit. 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 was 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 became apparent during the

observation study undertaken there, when it was seen to both symbolise and structure the medical hegemony of care.

'The board', kept in the midwives' office on delivery unit, in common with other units around the country (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.

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 (Box 1).

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.

Source Field notes: Maternity Hospital D.U.Observation Study No. 11

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.

The most important function of the board was to provide a checklist concerning every-one 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 enabled 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)

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.

Maintaining the Hegemony

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, an experienced sister advised me 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 – 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.

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 5). 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).

During the observation study, and from personal awareness during reflective practice, it was apparent that the majority of women remained on their beds throughout labour. Also, midwives were seen to be slow to encourage their colleagues to try the 'tricks' that can help when progress is slow. The high medical intervention rates could be as much a reflection 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). 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 DEPARTMENT

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.

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 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. 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 unit 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.

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 24-hour domestic staff available on the delivery unit, 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 idiosyncrasies of the permanent domestic staff become known, and confidence and a sense of satisfaction from their work could 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 be expected to 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 long-term 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.

Box 2

Another early shift in the maternity department. 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 probably 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 (ie. 07.30–21.30hrs)

Reflective notes

The caseload midwives think they work a long and busy day!

Look for such '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 Maternity Department 24th January 1996

A lot of time was spent 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 of staffing 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 Eleven and Twelve) and were unable to anticipate or plan their work, merely responding as directed, feeling pulled here and there rather like rubber bands.

Nevertheless, the unit held a 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.

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 in maternity department. Went to delivery unit, told to go to ward until clinic at 9am. Ward very busy as usual. I was asked to give drugs out. Whilst doing this three SHOs and some registrars on ward undertaking rounds simultaneously. Chaos.

I saw one doctor 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 Maternity Department 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 teaching hospital, the smaller maternity department appeared 'swamped' by the geography of the larger organisation, a phenomenon that was both symbolised in, and a reality of, the mothers' hospital notes. These were constructed with information concerning care being filed concurrently, irrespective of medical condition, rather than the maternity section being held as a separate or contained entity. Accessing new information in these notes was often time-consuming and frustrating for busy staff.

The maternity department also seemed threatened by the reputation of the larger maternity hospital. 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 COMMUNITY MIDWIFERY SERVICE

As previously noted the community midwifery service was administered from offices within the Maternity Hospital. Fifteen midwives (14 G grade, 1 E grade), and an administrator, worked in this service, which was organised into two teams and served the geographical areas surrounding both hospitals. Midwifery work constituted mainly undertaking postnatal visits on mothers who had delivered in hospital, running antenatal clinics in GP surgeries and some community based parent-craft classes. Interpartum work was minimal: the home delivery rate was very low and few community midwives actively promoted Domino deliveries in hospital. Although these midwives worked an 8am-5pm day Monday-Friday, they covered nights and weekends for emergency calls by a rota system.

CONCLUSION

This chapter has presented a description of the organisation and culture of the service in which the caseload midwifery was implemented. In both theory and ethos, the profession of midwifery was found to be unsupported, subsumed by a powerful medical orientation in one unit and a weak organisational structure in the other. This was the nature of the caseload midwives' previous midwifery experience and the context in which, at times, they had to work. Thus it provides a basis from which the challenges and adaptations they met can be understood.

This analytic description of the maternity service, as delivered through the two contrasting units, illustrates the manner in which organisational features control and construct midwifery work. Also, the dynamics of a medicalisation process of childbirth can be appreciated as complex and subtle, not merely a regime imposed by doctors.

The spatial construction of a unit offers an important, perhaps subconscious, influence on its culture. In the larger unit the railings and buildings suggested containment and cohesion, facilities such as the canteen the ability to construct and renew a common

identity. However, the tight grouping of the clinical area facilitated a sense of medical omnipresence; doctors were never far away, providing both a source for information and of control. Such phenomena were lost to the smaller department that was effectively scattered through the larger general hospital.

The highly medicalised orientation to birth that dominated the maternity hospital was maintained by midwives as much as doctors. Through reputation for research and clinical practice, obstetricians were the dominant professionals; they were respected by the senior midwives who tended to respond unquestioningly rather than challenge practice. Lacking educational and clinical midwifery leadership, midwives were not proactive in encouraging and supporting each other's midwifery practice, contributing perhaps to high medical intervention rates. Aids such as the board on delivery unit helped to structure and control the process of birth; although subverted at times, this imposed a time frame that denied a natural physiology of birthing. Such a hegemony was absorbed and re-enacted by the midwives, maintained through attitudes and practice rather than any form of coercion.

In the maternity department where a smaller obstetric presence supported rather than dominated the midwives, the development of a vibrant midwifery culture was curtailed by an organisation of practice that, although introduced to improve continuity of care, enforced a task orientation.

Both the cultures detailed above were challenged by the implementation of caseload midwifery practice and were difficult environments in which to produce autonomous midwifery practitioners; these themes will be picked up and developed in this thesis.

Chapter Six

THE CASELOAD MIDWIFERY PROJECT

INTRODUCTION

As discussed in the preceding chapter, maternity care in this particular service was highly medicalised, with midwifery lacking leadership and vibrancy. The need for change was recognised and the caseload midwifery project conceived. This chapter focuses on the project, considering the ‘what?’, ‘how?’ and ‘what was it like?’ questions.

Initially an outline of the organisational model of caseload practice is presented with details of the management support and resources allocated to the project. Although undertaken prior to starting this research, in acknowledgement of the impact the planning and implementation would have on the project, reflective reports about this process are considered.

The way in which the model was operationalised by the caseload midwives is explored to enable their work to ‘come to life’ and their story to be appreciated. A sense of the tensions that existed when the project was finally implemented is revealed, and an understanding presented of what it was like to be a caseload midwife and how they managed their work.

Acknowledging that things are not static, the strength of ethnography lies in the ability to consider the nature of an environment that is constantly changing. The caseload project was vibrant and evolving, responsive to its environment, but that environment was itself in a state of great change. The nature of these changes and uncertainties, and the manner in which they inter-linked, are explored in an outline of the project’s subsequent history.

Although not important for this thesis, in terms of the academic quality of the research, consideration of the evaluation is vital for the validity of the model. For all practical purposes this study would be worthless if the model was found to be clinically unsound. A brief overview of the wider evaluation is presented, indicating its breadth and depth, as a reassurance to the reader that this model was found to be viable.

CASELOAD MIDWIFERY – THE MODEL OF PRACTICE

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 this mission statement, the aims of the caseload midwifery project were twofold: to improve midwifery practice and to improve care provision for mothers. These aims were operationalised in the five principles for caseload practice (Table 6) and the organisational features summarised in Table 7. 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.

Table 6 Principles of caseload practice

<ul style="list-style-type: none">• 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 woman 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)

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

Table 7 Organisational features of caseload practice

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

Women living in the designated area were offered midwifery care from the project, irrespective of existing or potential complications with their pregnancy or delivery. Twenty midwives, already employed within the maternity service, 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.

Discussion with each mother determined whether an individual's care was led by midwife, GP or obstetrician. 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 (Table 8), reflecting many of those of *Changing Childbirth*, were used as the basis for audit and evaluation of the model.

Table 8 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)

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

Management Support

The work was undertaken as the first project of a newly established Midwifery Development Centre, a collaborative unit established by the Special Health Authority (SHA) and 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.

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 water-births, 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 student midwives seconded into the project, they facilitated and supported midwives with home deliveries.

An 'Action Group' of five experienced midwives was central to the planning and implementation of the project; the group comprised the midwifery professor, maternity services manager, project manager, lecturer-practitioner and researcher-practitioner. These senior midwives also provided 24-hour 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 Maternity Service 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.

PLANNING AND IMPLEMENTING THE PROJECT

As appreciated from the preceding chapter, this model of practice was developed within an institution where midwifery was not thriving. Context is not merely a 'backdrop' for the project but will affect the way a 'model' works in practice; the way in which it is planned and implemented will affect its reception by those working in the maternity service and the way it is 'allowed' to develop.

For this study the planning stages were not part of the data collection period and are understood as participants' reflections on the process. Three issues emerged as being central to this phase: the timing, sharing a vision, and communication, and are presented as part of the 'story' of this period.

The Time Was Right

The importance of timing for effective change is well-recognised (Moss Kanter 1988; 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. These included 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 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 months discussed in public, formed protocols etc; and six months dotting the i's and crossing the t's'*, 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 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 hospitals' 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.

The 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, where points of potential resistance were identified, addressing concerns by *'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 mis-interpret 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 maternity department were reported as presenting little opposition and, a manager suggested, *'didn't notice the caseload project arriving'*. Conversely in the larger maternity hospital, 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 their spirit was re-vitalised when a consultant called them at home one Saturday morning with the comment: *'You've got to go for this project. And if it fails, so be it. Try it.'* 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 vocalised 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, 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 purpose was to discuss the philosophy of the project, promote a similar ethos of practice and ensure candidates were aware of the implications of caseload midwifery.

Interviews were held during the early summer months of 1993, involving a consumer representative on the selection panel. Twelve months' clinical experience was a mandatory requirement, but the selection focused heavily on the demonstration of 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 equally 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 Eight 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.

Although implementation of the caseload 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 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 Start

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" (then said as an aside) but I don't know how it works.' (fg.om.pm12 and 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 established 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 (Chapter Seven) and the midwives' transition into caseload practice (Chapter Eight).

CASELOAD MIDWIFERY IN PRACTICE

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. In understanding the experiences of the caseload midwives, acknowledgement of a profile of the mothers they were serving is important.

This information was gained from the 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 department, located in a more socially deprived neighbourhood than that served by the maternity hospital.

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 department 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).

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.

Over time, clients who presented 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 to meet 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, given their detailed knowledge of the family's particular circumstances, they could offer appropriate midwifery care.

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 yet to 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 – 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 and the Head of Midwifery retired in the following year; that position was redefined to one with less power and left vacant 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 the 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 were 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.

The Caseload 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 replacement 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 unrepresented 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.

THE EVALUATION

Acknowledging that 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. Originating as part of the evaluation, the understandings generated by this ethnography were, in a sense, triangulated further by the wider research. The protocol developed (Page *et al* 1994) utilised:

- 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 or organisational change and its meaning to professionals.
- A comparative approach, to compare caseload midwifery care with the system of care it replaced.

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. 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. The caseload midwives were clearly aware of the evaluation and full co-operation was an expectation of their selection. 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 1997-98, a period which covered the end of the ethnographic study.

The report of the first evaluation was produced in 1996 (McCourt and Page 1996) and the findings published in a variety of reports and journals (McCourt 1996, 1997, 1998a, b, 2000; McCourt *et al* 1998; McCourt and Pearce 2000; McCourt and Beake 2001; Harper-Bulman and 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. Nevertheless, 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 proved 'successful' on both evaluations.

CONCLUSION

This chapter has contributed to the picture of the context and outlined the 'theory' and 'practical' interpretation of the model that is analysed in depth in this thesis. The

philosophical and organisational framework for the caseload model has been detailed, the manner in which it was implemented and operationalised by the midwives described and the way it evolved, responsive to the changing circumstances of the maternity service of which it was a part, discussed.

The preceding chapter described the service in which this project was conceived and later 'supported', the 'soil' in which caseload midwifery developed. The competing demands made on that 'soil' and the influence this might have had on the development of the project, will be addressed in the following chapter. It explores the reactions of those who continued to work in the conventional service, alongside and interacting with the caseload practitioners.

Chapter Seven

THE PROFESSIONALS' RESPONSES

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

INTRODUCTION

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. Chapter Five painted the picture of a service that apparently needed change, particularly the maternity hospital, but seemed unlikely to cope with it that well due to some of the issues highlighted. The subconscious maintenance of a medicalised hegemony by a midwifery staff lacking vision and leadership, and the unquestioned dominance of the obstetricians, indicated that caseload practice would present both a symbolic and actual challenge to the *status quo*. 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.

OVERALL PATTERN OF RESPONSE

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.

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.

THE 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 was 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.'

'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.' (all from 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 birth 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 choose 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 acknowledged 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. sonic aids. This mistake is illustrative of community midwifery being seen as an 'occupational group' rather than 'profession' (*see* Chapter Nine); 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 but 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 earlier in the chapter, 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.

Concern 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, mirroring the initial concerns expressed by the caseload midwives themselves (see Chapter Eight). 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 the division of responsibilities and how the system worked. Midwives complained that things kept changing and information altered, which caused 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 eg. 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; eg. 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 unnecessary 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 – (eg.) 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' orientation.

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, summarised in Table Nine, was a thread that ran throughout the conversations.

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, eg. 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:

Table 9 Uses and abuses – hospital midwives’ complaints

<p><u>Clerical tasks</u></p>	<p>Expected to locate 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.</p>
<p><u>Clinical tasks</u></p>	<p>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).</p>
<p><u>Equipment</u></p>	<p>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 and equipment very messy.</p>
<p><u>Personal issues</u></p>	<p>They were untidy; left personal possessions lying around. Unprofessional – some dressed sloppily. Identity passes not clear; new midwives and students were a particular problem.</p>
<p><u>Blocked resources</u></p>	<p>Use of computers, of phones and clinic room: <i>‘There’s not just one but 20 of them!’</i> This held others up.</p>
<p><u>Held up system</u></p>	<p>Delay in getting ‘bookings’ back into system if caseloads are full; slower – took longer time to book women (blocked the room). Blood results slow to get into notes – collected – needed filing</p>
<p><u>Communication</u></p>	<p><i>‘We are always on phone trying to get them.’</i></p>
<p><u>Mediation</u></p>	<p>Having to act as ‘go-between’ – consultants not understanding or didn’t listen or understand properly. Consultant putting moral blackmail on client and 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.</p>

'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)

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 third stage*', and '*leaving students with women in labour, telling them to call when nine centimetres 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 situations. In the situations identified caseload midwives were considered to '*take risks in the name of progressive midwifery*', although such practices are the norm for other units (personal experience).

Communication, as detailed previously, and attitude proved the most widespread complaints. Several noted how caseload practitioners were seen as being elitist, '*they're*

above themselves’, and a ‘them and us’, divisive reaction was highlighted. All grades acknowledge that some of the caseload midwives demonstrated an attitude they found difficult to handle:

‘It’s not so bad now the aggressive ones have gone. It seemed to them that they were up here (indicated high) and that we are rubbish.’ (fg.hm.’96)

‘You get a sense of superiority from some of the caseload midwives. They’ve got an air when they come in, “you’ve got a uniform, I haven’t” attitude.’ (fg.anc.’95)

‘At the beginning they were all very superior to everyone else – “Well I’ve got the courage, I’m independent!” (fg.anc.’95)

Yet these midwives also recognised the hard time initially experienced by the caseload midwives, which contributed towards their attitude and:

‘... the need to project an air of superiority even if they don’t feel it – to give an air of confidence.’ (fg.anc.’95)

In relationships with hospital colleagues, it was clear that the caseload midwives made mistakes and inadvertently upset individuals by their attitude. However, over time hospital midwives reported they *‘got to know which midwives are more approachable’*, much as the caseload midwives identified when relating to the obstetricians.

Nevertheless, the problem was not generated one-way. E grade midwives noted how the attitude of senior staff had fuelled tensions by:

- Actively creating conflict situations; eg. a sister on delivery unit told a new registrar that she *‘Didn’t know what was happening’* in the room, and did not present a sympathetic introduction to caseload practice by saying *‘they can’t stop you from asking’*, *‘go and knock on the door’*. Such sisters were considered to fuel rather than defuse potential conflict situations.
- Inappropriately calling the midwives for little things: *‘Some would call if women wanted paracetamol!’*
- Not offering help:

‘...when obviously a caseload midwife has done her caseload during the day and then is awake through the night looking after someone in labour. There’s been times when we’ve been very quiet on labour ward and not one person has asked that midwife if they’d like to be relieved for a break or if they’d like a hand with the paperwork after the delivery.’ (i.hmE02/3)

One midwife reported being told-off for offering help by the midwife in-charge saying, 'no, you shouldn't do that, no, you don't need to do that'.

'On delivery unit we were told not to co-operate "It is none of our business". The problem is always at sister level, a few of the sisters, the senior G grades, they told us not to help. I would ask the sister if I should relieve the caseload midwife and she would say "No, they will come and ask."' (fg.anc.'95)

This attitude was considered to have diminished but it had not completely disappeared by the end of the data collection period; as some noted, 'it was always the same few'.

Nevertheless, this situation was not directed solely at the caseload midwives. Community midwives were observed to be similarly ignored on the delivery unit, and one of the E grades noted how she had received similar treatment when delivering a friend in her own time. She was absolutely exhausted and no offer of help had been forthcoming.

It was clear the hospital midwives' negative responses to the caseload practitioners moderated over time. They became familiar with and more accepting of different styles of practice, and complaints became focused on the individual rather than whole. In discussing the interface situations, the midwives noted how some practitioners were 'always there' for their women whilst others found it easier to negotiate care provision with hospital staff. The need for good communication, for 'professional negotiation', asking rather than demanding care from hospital staff was emphasised:

'It's just a matter of experience that we all learn that we've got to help each other.' (i.hmG04q)

'Some you can tell (correct) others think they know it all.'
'And these are people who have less experience than you have had'. (f.g hm.'96)

It was recognised that a few 'difficult' midwives gave the system a bad name but that the 'good' ones did not mean it had a good name; nevertheless 'good' caseload midwives became recognised and valued by those in the hospital.

Clearly the change in people's attitudes was aided by staff movements into and within the unit, facilitating a spread and airing of different perceptions. The graduation and retention of ex-students who had personal experience of caseload practice was particularly useful as their input into a more accurate understanding of caseload midwifery helped address misperceptions and misunderstandings.

Discussion

The hospital midwives' perceptions and problems reported by both caseload and hospital midwives at the 'interface', may be understood as representing a clash of systems and conflicting interpretations.

Hospital midwives worked in a system that forced them to be tightly focused in their work, frequently within pre-defined, task-orientated boundaries that were further limited by the time constraints of a duty-rota. Required to be responsive to situations and the needs of others (both medical and client demands), the midwives were effectively controlled in what they did, and unable to exercise much autonomy or responsibility. This contrasted with the nature of caseload practice. Although responsive to the demands of their caseload, caseload midwives were able to exercise a high degree of autonomy over the organisation of their work. At times under pressure, disturbed by phone calls and the occasional 'long haul' caring for a labour after a day's work, these midwives were generally more relaxed and flexible in their attitude towards their work, which was long-term and on-going rather than limited by time, task and place.

The interface tensions were generated partly by conflicts over the use of time and nature of work, issues which, emerging as major themes in the analysis, are considered in-depth later in this thesis. Particular situations were interpreted from different perspectives and this inevitably generated tensions. However, all the original caseload practitioners came from the conventional system, were well known, and had personal experience of the pressures experienced by their hospital colleagues. It might have been expected that allowances on both sides would have been made. That this appeared not to have happened demands consideration.

In undertaking caseload practice, these midwives actively and verbally rejected the conventional systems. The challenge they accepted was not easy, and the demands placed on them appeared to reduce their tolerance towards the weaknesses of the conventional system. Perhaps, being forced to define the boundaries of midwifery to themselves and their clients, they were not prepared to compromise. This became apparent when they were expected to undertake what they considered were non-midwifery duties, such as cleaning a room after delivery. However, without a cleaner midwives had to undertake such essential tasks and the hospital midwives were understandably annoyed to be left, both literally and symbolically, to do the '*dirty work*'.

The caseload midwives' interpretations of the nature of work had also changed; they reported coming to value the time spent talking to women, and learnt that action on many occasions involved the decision not to act. This contrasted with the busyness of hospital midwives who interpreted such 'inactivity' as 'laziness'. Caseload midwives were, at times, apparently unaware of, or impervious to, the impact their presence had on their colleagues. In complaining of the unexpected political nature of their work; they were, in reality, politically naïve, undoubtedly generating tensions that could have been avoided with forethought.

THE OBSTETRICIANS' RESPONSES

Consideration of the obstetricians' responses is made acknowledging the special features of the maternity service outlined in Chapter Five. The Trust was recognised as a leading postgraduate training site and held an international reputation for high quality medical research; all junior doctors were career obstetricians with previous obstetric experience. The larger unit promoted a medical model of childbirth; the smaller unit specialised in supporting pregnancy in women with medical conditions. With no tradition of midwifery-led research or practice, the implementation of caseload midwifery within this highly medically-orientated maternity service was seen by members of the 'Action Group' as an extreme test of the model.

An analysis of the obstetricians' views, is written-up elsewhere (Stevens 1995); this presents an overview of their initial reactions and subsequent experiences. Consideration of the maternity hospital obstetricians' reactions, is informed by the observation study undertaken on that delivery ward. This offered an important understanding of the obstetrician-midwife relationship in this unit so is included in this section as part of the description of the context in which caseload midwifery developed.

Initial Views

Although some senior obstetricians were reported as '*rather difficult*' during the planning stages of the project, when interviewed they vocalised quite positive views concerning caseload midwifery, acknowledging that, as well as offering women a more individualised service, the model held the potential for professional development for midwives. Also, by removing the 'normal' from obstetric practice, some consultants considered it enabled the

doctors to focus more on abnormalities and research, and might offer political advantages to the Trust.

However, they also expressed a number of concerns, particularly questioning midwives' ability to undertake the work, fearing they would not recognise problems or would exceed their role; the requirement for further training was suggested. Such concerns reflected these obstetricians' experiences of taking a dominant role when working with midwives, thus having minimal experience of them as autonomous, accountable practitioners (WHO 1966, 1995). This situation was reflected in the second area of concern, that of 'ultimate responsibility'. If the midwives made mistakes the medical-legal consequences were considered to fall on the obstetricians, even though they were not involved until 'too late'.

The potential for the service to prove divisive, creating a gap between doctors and midwives, was raised by both consultants and junior doctors; the spectre of radical midwives promoting home deliveries was a concern expressed by both groups. Considering recent NHS cutbacks, eight doctors questioned the financial viability of the service, clearly considering it to be more expensive. Moreover, at a time when doctors were facing cutbacks in junior doctor hours, disbelief was expressed that midwives would be prepared to take on such a 'demanding' way of working; suggesting it may only *'be possible with a group of real enthusiasts'*.

Subsequent Experiences

Although interviews with the obstetricians were conducted when the project was still 'young' (12-19 months), they identified positive features already experienced. Midwifery input into complicated cases was valued: providing background information and acting as advocates for nervous women helped ensuring appropriate care was negotiated.

A few considered caseload practice had made the service safer. They felt reassured the midwife would check laboratory results and regular blood pressure readings, reporting concerns directly to them. Such close follow-up and communication, particularly with the difficult cases, was considered to make care considerably easier for the doctors.

Given the concerns expressed about midwives abilities to undertake this work, the doctors were very positive about their development. Several admitted being surprised and reassured about the midwives' competency and sense of responsibility, and their obvious professional development was commented on.

Nevertheless, problems had been encountered and were reported by obstetricians, caseload and hospital midwives alike. Most concern had been generated about the role the obstetricians played on delivery unit in the larger hospital, and their involvement with low-risk women in labour. In this unit, obstetricians regularly conducted 'medical rounds', visiting and assessing care of all women on the unit when they changed shifts. The midwives reported this as unnecessary and obtrusive for women with uncomplicated labours and the caseload midwives strategised to avoid such visits. However, such actions merely served to irritate obstetricians rather than resolve the issue. A consultant spoke of '*not being allowed to talk about project cases*' when undertaking teaching rounds; a registrar noted how '*the senior sister and SHO don't know what is happening to project mothers*', and how the caseload midwives '*guard the door*'; whilst an SHO reported '*we've all had situations where we've been refused entry to a delivery room*'.

Asked why they felt it important to visit each mother, the obstetricians talked of the importance of a '*social visit*' where they introduced themselves so women would know who they were if called in to assist:

'Seems the height of rudeness, particularly if it's very urgent and you don't have time to, you know, establish a rapport and suddenly you've got to put forceps on her baby, cut her...' (i,jo).

The doctors indicated that they had no intention of interfering with the management of the case, although midwives reported experiencing otherwise.

Although suggesting the caseload midwives had developed favourably, some were reported as becoming '*a bit above themselves*'. Junior doctors questioned the basis of authority from which some were working as many of the original midwives' experience was known to be limited and their attitude clearly aggrieved some:

'She gave the impression that she didn't really respect my opinion to be honest, um, and that she knew better.' (i,jo)

The 'superior attitude' of some of caseload practitioners was also noted by senior doctors but perceived as conflicts with hospital midwives; an example cited was the caseload midwives not staying behind and clearing up after themselves.

Although not considering them serious, four obstetricians commented on clinical mistakes the midwives had made early in the project. The potential for mistakes had been a major concern; however, few had been identified and the audit of care indicated no difference between hospital and caseload care. If mistakes were made they had not been uncovered, but the potential for this was present in people's minds.

Discussion

The implementation of caseload practice appeared to have both practical and psychological implications for the obstetricians.

Many clearly valued working with someone who had knowledge of the mother's wider situation, discussing appropriate care plans with them, and gaining a sense of reassurance high risk women could be monitored carefully without hospitalisation. Several considered it made their work more enjoyable and easier:

'I enjoy seeing the patients with the project midwives. If you work alone, I mean, consultant's sort of road is quite lonely in some ways, you get used to making decisions along certain lines and, er, to hear someone else's views as to what might be done, I think, is often refreshing.' (i.co)

Some were concerned about the inequality of care it caused some women in both systems of care, citing jumping the queue situations in antenatal clinic and being ignored on the wards, suggesting *'it's a bit like a private patient who gets ignored.'*

The advantages it generated for the doctors in terms of freeing up their time for research and care of abnormalities was valued. Nevertheless, a potentially negative impact on their training was also highlighted; reduced involvement in 'normality' was feared to warp their view on childbirth in general, and concerns expressed when they were excluded from decision-making processes if the midwives liaised directly with registrars. The requirement for junior obstetricians to follow care into the community as part of their training was a solution suggested by one consultant.

Concerns over the potential for litigation, and public and peer castigation, proved a serious issue for the doctors, understandable in the light that these were career obstetricians with reputations to maintain.

'There has to be an element of shared responsibility and that certainly worried some of my colleagues and I think it may still do. No doctor likes to be sued for somebody else's mistakes, because it's a very time-consuming, painful and damaging process, being sued. They'll get their names in the papers. And it gets about, because although it's not publicised, there are all sorts of expert witnesses that are involved. So it's not something that happens strictly in private.'

Researcher: 'So its the informal networking that can actually damage your career?'

'Yeah. (pause) And of course injured pride.' (i.co)

The more junior doctors feared the internal post-mortems and open criticisms associated with a poorly handled case, too many of which could detrimentally affect their crucial references. Both concerns reflected the inaccurate assumption that obstetricians held ultimate responsibility for midwives' actions.

This analysis does not help explain why the actions of some of the doctors denied the support they offered during interview. During the early days the obstructive behaviour of some consultants was reported by both caseload and clinic staff on an almost daily basis. An example was how one consultant demanded to talk to mothers alone at booking to present the value of obstetric care rather than caseload care – something the caseload midwives considered as *'playing games to make a political point'* although the clinic sister considered this distressed mothers.

Such consultants were thought not to understand the new system. However, during interview a clear understanding of the project was elicited from those reported to be most difficult; nevertheless, the indication of a more fundamental issue was highlighted. Vehemently objecting to the *'secrecy'* with which the project was introduced and run, and protesting they did not know anyone in the project, one consultant was then unable to recognise the name of the Directorate Midwifery Manager; another complained about not being told about the project, yet the minutes of the Joint Medical Committee (JMC) indicated their absence at any of the many meetings where the project was discussed.

Such data suggested that some of the obstetricians were using the project as a vehicle for expressing concerns about their diminishing influence on the management of the maternity service, as a result of the introduction of a more professional management system with clinical directorates and the concurrent demise in the authority of the JMC. It might also reflect their concerns about changes in the power balance between obstetricians and midwives.

The indication that caseload midwifery presented a more fundamental threat to some obstetricians was made by other consultants:

'I don't think a number of them wanted it at all. I think they almost saw it as a threat. A lot of people expressed a lot of anxieties which seemed to me to be unreasonable and even if they were reasonable they were expressed much more vociferously than is appropriate. It really seemed to hit a nerve with some people and my interpretation at the time was that a consultant obstetrician, who has been a consultant for years, to be suddenly told that most of what he has been doing for most of his life can actually be done by a midwife – it's a little bit of a shock. What they were saying was that the midwives are not sufficiently qualified to undertake this role. But I suspect the underlying anxiety is the exposure of the fact that a lot of what they've been doing for a long time is not that difficult.' (i.co).

Such reasoning might help explain why the caseload practice logo, stuck on women's notes for ease of identification, perpetually enraged one consultant who would then surround it with their personal identification label. This example of symbolic territorialism, was frequently commented on by clinic and caseload midwives alike, during informal conversations.

With time, the caseload practitioners identified which obstetricians were most accessible and directed their queries accordingly. It became apparent that the greatest support came from obstetricians whose interests were known to lie in research or complicated obstetrics. With a few exceptions, those with less specialised interests were considered more 'difficult', making demands the midwives considered unreasonable (eg. routine vaginal examinations at booking); they tended to be avoided by the midwives. The connection may be coincidental so inferences are drawn with care, but the data is suggestive of a sense of threat experienced by some consultants by the establishment of caseload midwifery. One consultant also noted how the caseload midwives disrupted the professional relationships established between General Practitioners and obstetricians, by-passing the referral system of a consultant-led service with direct personal contact.

'You know, it was impinging on their territory. In a sense of their own importance – you know – power, and that sort of thing.' (i.co).

These tensions diminished as the midwives developed strategies of accommodation and avoidance and, with time, several obstetricians retired.

However, although a sense of marginalisation might indeed have been a problem for some consultants, the data does not support this as the reason behind the tensions that developed on delivery unit. In view of the seriousness of the friction reported by both midwives and obstetricians alike, a specific period of focused observation of the relationships enacted during the ward round was undertaken. Analysis of this data suggested an alternative interpretation that, again, focuses on the issue of ultimate responsibility.

The issue was originally identified during an interview with a senior registrar who noted how medical staff would check the midwife's capabilities:

'I also think there are good midwives and there are bad midwives. And you sometimes feel an obligation to keep an eye on some of the midwives' care to make sure they are picking up problems and so on. I'll go in there and suss them out. Sometimes they say really bizarre, odd things, and then I'll feel obliged to make sure that someone's keeping an eye on them.' (i.so)

This phenomenon was repeatedly observed during the observational study. Usually the medical team, accompanied by the senior midwife in charge of the unit would visit each mother admitted to the unit. When alerted to their presence by a knock on the door, the midwife would appear with the mother's notes, provide a brief resume of the situation whilst the registrar leafed through the pages, respond to queries raised and accompany the team back into the room. The subsequent division of labour involved the senior doctor introducing the team to the parents, examining the mother's abdomen, discussing a plan of action with the midwife and parents, and leaving. The junior doctor checked the foetal heart monitor if applicable, wrote in the notes, and followed the team to the next room. The social component of these visits varied but was limited and clearly in the control of the senior obstetrician.

In the eleven visits interpreted in the analysis as a purely '*social visit*', much of the social component was lacking and few of the norms of social etiquette were observed. Also, nearly half of the women were not visited – 35 of 75 women. Of these 12 had delivered, two were private patients, it was considered inappropriate timing in seven cases; 14 women were just missed. On no occasion did the obstetrician return to visit a woman they had been unable to see. If the intention of the 'round' was to introduce themselves to women they may be called to assist, it proved singularly inadequate.

What became apparent was the importance of the negotiation held outside the door, before the team entered or walked away from each room and the way midwives handled the briefing. In my presence, without exception, the doctors responded to the midwife's management of the situation. Where a clear and concise history was presented, an appropriate plan of care outlined and the midwife appeared in control of the situation, the obstetricians minimised the visit and, if low-risk cases, were less likely to enter the room. Where the midwife was confused or was observed to make clinically inappropriate responses to their questions the doctors focused time and attention on the case and, on leaving the room tended to confirm their instructions to the sister-in-charge.

Although limited in number, observation of the obstetric round on delivery unit clearly indicated the way the doctors used it for assessing midwifery capabilities; the analysis suggested the importance placed on undertaking a 'social visit' was less important than that of 'checking the midwives'. If any value is offered by a 'social visit' during labour, and Proctor's (1998) findings suggest some women do appreciate this, it could be more usefully conducted by the SHOs who, undertaking longer shifts could meet women shortly after admission in labour and would be present at all stages of any future decisions and procedures.

This observational study helped confirm the doctors' attitude of accepting ultimate responsibility and the importance individuals placed on trust. When viewed as a test of midwifery capabilities and clinical check rather than as a social visit, the ward round becomes an essential strategy for doctors who assume responsibility for client care and thus, indirectly, midwives' practice. That midwives have 'allowed' this situation to develop is a reflection of the gradual decline of midwifery independence and assertion of obstetricians' control by various means, including National and regulatory level, as detailed in Chapter Three.

In the local situation, it may be understood in a context where medical staff had long dominated the management of childbirth. This caused midwives to be unable to hone, or even lose, their decision-making capabilities by turning to the ever-present doctors for advice, confirmation and management plans - a situation identified elsewhere by Robinson (1989), Aksham and Barbour (1996) and Chamberlain (1996). Those, both caseload and hospital staff, who argued clear and appropriate plans were left alone.

In a situation where midwives were to assume full responsibility for some women, the senior doctors had little 'proof' they could undertake this and their reactions demonstrated a concern for the welfare of the women. It was an iterative process – until given responsibility, midwives were unable to develop the skills required; when responsibility was taken away they lost incentive and became deskilled. The implementation of caseload practice challenged the situation. Lacking authority at organisational or professional level, the midwives had to earn trust at individual level and, until established, tensions developed.

Trust had to be earned, once gained and maintained it proved the vital lubricant that soothed the interface between obstetricians and midwives and between the midwives themselves.

CONCLUSION

This chapter has focused on the reactions and perceptions of the midwives and obstetricians working in the conventional service, alongside the caseload practitioners. Such responses present more than academic interest. Caseload midwifery was situated within a particular professional environment and the caseload midwives were reliant on their midwifery and obstetric colleagues. Their reactions would, therefore, impact on the experiences of the caseload midwives and the manner in which the project was able to develop.

Of particular note in these reactions was the almost universal support for the ideology of caseload practice, although many suggested it might not be realistic in practice. All types and grades of respondents considered the project as holding benefits for mothers; even the complaints that it was elitist were framed in a concern that it benefited a few, not all mothers. This suggests a wide awareness of the deficiencies of the service these practitioners were currently providing. It also contributes towards a picture of staff, both midwives and obstetricians, as basically caring individuals who genuinely hold the wellbeing of their clients to heart but are forced to work at a pace which denies individuality and enforces a clinical focus in which issues of safety predominate.

For midwives caseload practice was generally seen to be closer to the image of the profession; although many did not choose to practice in that manner, they recognised the advantages it held for midwifery practice. However, caseload practice clearly presented a devaluation and real challenge to community midwives, increasing their insecurity in an insecure climate. Hospital midwives were less threatened by the project, recognising the security of their position within the medical service. However, they were antagonistic to the project midwives, irritated by the perceived extra work incurred when they were already over burdened and, at times, envious of their position particularly in terms of the quality of midwifery work that could be achieved. Such envy illustrated recognition of the constraints the organisation placed upon their midwifery practice.

The indication from the overall responses was that problems were less likely to lie with obstetricians than with midwives. Although obstetricians who were closely involved in 'normal' childbirth had problems accepting the project, it was cautiously welcomed by those specialising in medical research and obstetric complications. Their concerns lay in midwives' willingness and ability to work in the way proposed. Obstetricians concerns about midwifery abilities also predominated on 'delivery unit' where the obstetric round was seen to be as much an assessment of the midwife as the mother cared for. This assumption of 'ultimate responsibility', which denies the legal standing of midwives as responsible practitioners, reflects an organisational structure that denies midwives autonomy and responsibility. Changes in this structure, as in caseload practice, will be seen to challenge the orientation of obstetricians as well as midwives.

PART FOUR

CASELOAD MIDWIFERY PRACTICE

Overview

This section, comprising five chapters, presents the analysis of caseload midwifery. Examining the differences between conventional and caseload midwifery practice serves to highlight the ways in which organisational features influence midwifery work.

A profile of the 35 caseload midwives studied provides the basis for this understanding about caseload practice. Although joining at different stages of the project, it became apparent the adaptations they faced were common to all. Many of the changes were obvious; however, others were less tangible and possibly unrecognised by their colleagues. Using the analogy of an iceberg, these adaptations are explored in Chapter Eight.

Once confidence was established, the midwives reported enormous job satisfaction from working this way, considering this to be “*real midwifery*”. An exploration of this different form of midwifery, and the sources of the satisfaction they achieved, is presented in Chapter Nine. This indicates a fundamental change was taking place in the midwives’ orientation to their work and the profession, depicted as the bottom layer of the iceberg.

The nature of such fundamental change involved recognition of the ‘self’ of the practitioner, and the development of reciprocal relationships with mothers. This influenced the locus of power within the relationship, something that was already altered by midwives working as guests in mothers’ homes rather than the institution’s hosts. Such movement held the potential for empowerment of midwives and mothers, and the development of a new form of professionalism based on positions of equality. These theoretical propositions are explored in Chapters Ten and Eleven.

However, an even more fundamental phenomenon was identified as underpinning caseload midwifery. This concerned the different ways that time was conceived and used in the maternity service and caseload practice. The analysis of this, presented in Chapter Twelve, provides a understanding of many of the tensions generated during the implementation. It also suggests why caseload midwifery is not suited to all practitioners and should not be imposed on midwives.

Chapter Eight

BECOMING A CASELOAD MIDWIFE

INTRODUCTION

This chapter provides an understanding of the adaptations the midwives faced when they moved into caseload practice. In doing so many of the differences between conventional and caseload practice are highlighted. Individual's experience of these adaptations may have differed but a commonality in phenomena were identified, indicating these as likely to be substantive features of caseload practice. A profile of the caseload midwives is presented initially to provide an understanding of the type and experience of practitioners from which this understanding has been generated.

PROFILE OF THE MIDWIVES SELECTED

The caseload midwives are considered as two distinct groups: the original practitioners and those who subsequently joined the project. The original twenty accepted the challenge of implementing a new and high profile model of care, working under the microscope of public and research inquiry. The subsequent midwives had the advantage of the experience and lessons learnt from the 'pioneers', the facility of watching to 'see if it appealed to them' and, for many, the ability to 'test' working this way by accepting a short-term contract covering maternity leave. Such a 'wait and see' approach was suggested with four of the subsequent appointees who had been suitable candidates for initial appointments but had not applied with the original group. Although the basic characteristics of the two groups of midwives appeared relatively similar, personalities were likely to be different, as denotes pioneers who blaze a trail and subsequent workers who lay and establish the foundations.

An outline of the personal profile of the caseload midwives is presented below. Twenty midwives were initially appointed to the project. Subsequently 17 appointments, involving 16 individuals, were made for maternity leave cover and replacement of those who left. Data from 15 of the 16 individuals in the subsequent group are presented; one person left shortly after appointment and was never involved in the study. Data from another individual, initially appointed to cover a maternity leave who then left and returned when a

permanent contract became available, has been presented as one person, the data being taken from the time of their first appointment.

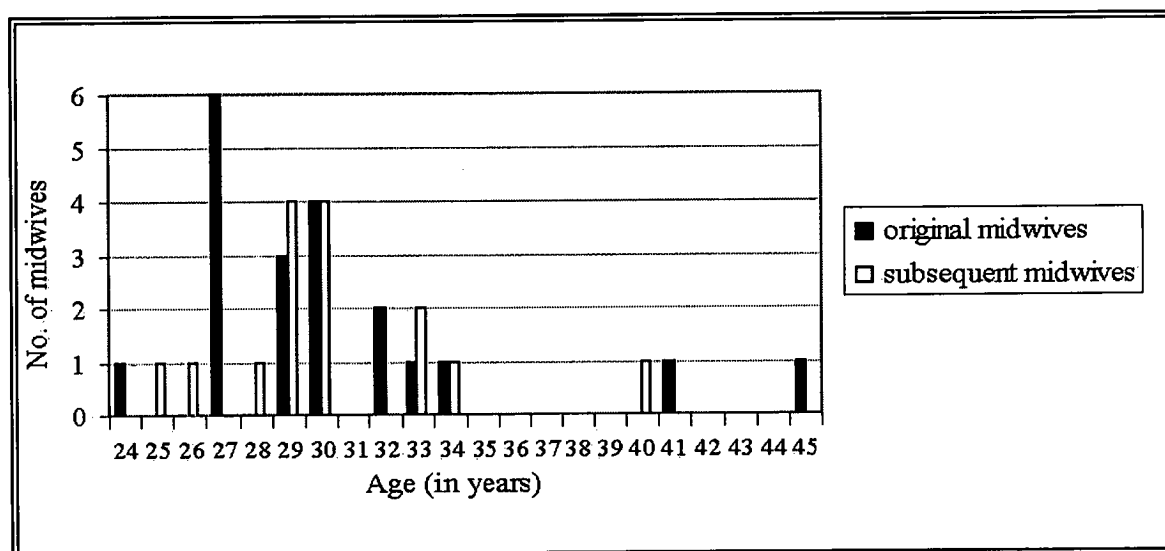
Gender

One of the original midwives was male and, during the study period, two male midwifery-students worked in the project during their training; both subsequently joined the practice after the data collection period was completed.

Age

Table 10 indicates the age profile of the midwives. The mean age of the midwives originally joining the project was 32 years (median 30, IQR 30-34). Although their average age was typical, this is a somewhat narrower age range than found among midwives nationally (UKCC 1996) and younger than those typically working in the community (Sandall 1998). The mean age of the subsequent group was similar although the range was slightly narrower (24-45 years for original, 25-40 years for subsequent group).

Table 10 Age profile of caseload midwives on joining



Family Responsibilities

Three of the original midwives and six of the subsequent midwives were married when they entered caseload practice; several more were living with partners. Three subsequently married whilst working in the scheme. Only one midwife had a young child to care for when they started working this way; six took maternity leave during the data collection period. Of these, two intended to return into part-time hospital-based midwifery; four returned or intended to return into caseload midwifery, two in a job-share arrangement;

three subsequently left. No midwives reported having other responsibilities, such as elderly relatives to care for, whilst working with a caseload.

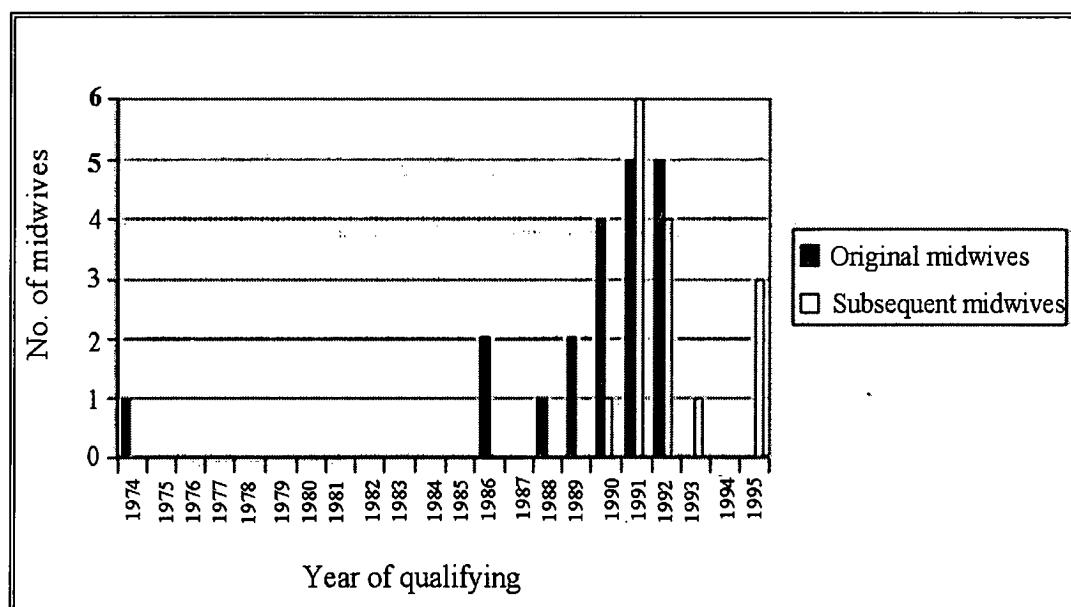
Training and Experience

All the midwives except one originally trained as nurses; the exception was a direct-entry trained midwife. Eleven of the original and four of the subsequent 15 midwives had trained at the study site (15/35). The majority of midwives had certificate level training; two of the subsequent group had diploma level and one a BSc degree in Midwifery. Two midwives already had degrees when they started caseload practice (BA Anthropology and BSc Health Studies) and ten midwives undertook courses whilst in the project; these ranged from the Supervisors course to modules in midwifery at either BSc or MA level.

All the original midwives were internal appointments, three from the community service and 17 from the hospital. Eleven of the 16 subsequent appointments (15 individuals) were recruited internally, all from the hospital service; four midwives had never worked within the Trust.

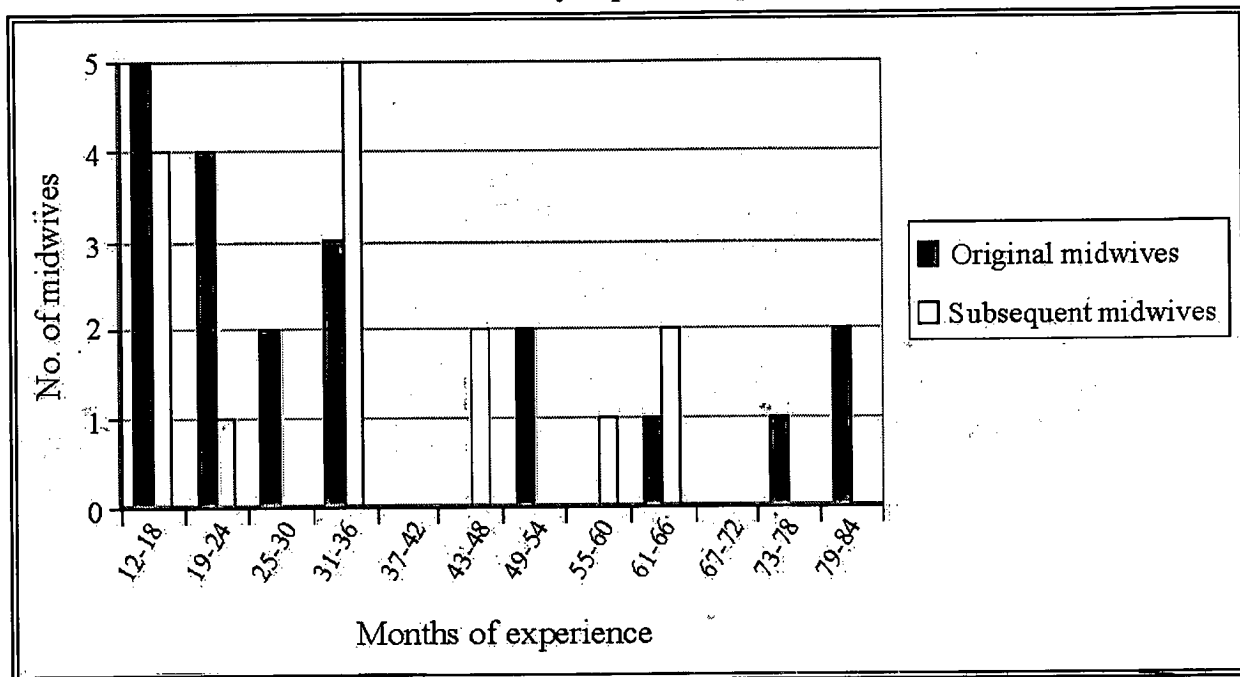
The midwives' degrees of experience are presented as Tables 11 and 12.

Table 11 Year caseload midwives qualified



Both the year of qualification and months of previous experience are presented in recognition that the nature of midwifery training has altered considerably over the years, and that many midwives may not practice continuously following training.

Table 12 Caseload midwives' midwifery experience prior to joining



The length of midwifery experience for both groups was similar on average (mean 3.75 years) but there were fewer of the subsequent midwives with only one or two years' experience (median 4, IQR 2-4.5 years).

Other Experience

The most noticeable difference between the groups related to the other experiences they brought to their work. Eight of the original midwives had worked overseas; others brought experience working in accountancy (2), in business (2), as a publican, a librarian, and working with the homeless; one, as a member of the Territorial Army, had been involved in the Gulf war. A higher proportion of the subsequent midwives were married and only four had worked overseas or travelled extensively.

Motivations for Joining

The reasons midwives chose to work with a caseload were sought during personal interviews and later by survey questionnaire. The responses received from both data sources were similar although the interviews reflected a depth of feeling not articulated in the survey response. Again it is helpful to consider the midwives as two separate groups; the reasons for joining given as questionnaire responses are presented as Tables 13 and 14.

Table 13 Reasons for Joining – Original Midwives

17/20 respondents

Rejection of the existing system – 13

Terms used = dissatisfaction / disillusioned / frustrated

- With fragmented care of women
- System not meeting women's needs
- Believed it was an improvement on the existing system
- Frustrated with the hospital medicalisation and hierarchical medical orientation
- Midwife low esteem due to system
- Unable to use all midwifery skills
- Increasingly frustrated with lack of continuity and disjointed care in hospital
- Wanted to practice continuity of carer rather than fragmented care in hospital system

Challenge – 5

- Wanted a challenge and to move the profession forward
- Wanted to be part of an innovative scheme
- Participation in a pioneering project

Promotion – 4

- For personal and career development (had been E grade for 3 years)
- Promotion

Improved Midwifery

- Gain greater skills
- Practice as a midwife
- Wanted to practice as a midwife not an obstetric nurse
- To maximise my role as a midwife to fulfil the criteria set down by *Changing Childbirth*
- To improve managerial skills overall
- More respectful relationship with fellow health professionals
- Desire to work with similarly motivated midwives sharing similar philosophy

Personal Practice

- Personal – I liked the idea of providing holistic care and utilising all my skills
- Professional – to promote holistic care to set group of women and families
- Wanted to practice autonomously – 5 stated this
- Expected more flexibility

Continuity – 6

Increased job satisfaction – 2

Environment – 4

- I wanted to use my midwifery skills away from a hospital environment
- Work in the community

Source questionnaire 1997

Table 14 Reasons for Joining – Subsequent Midwives

13/15 respondents
Caseload Midwifery – 7
<ul style="list-style-type: none">• Liked the idea of caseload management• Only ever interested in practising truly autonomous midwifery – therefore caseload practice seen as ideal goal• Experience working with caseload• Own caseload• Interested in caseload midwifery• To be able to carry a caseload to promote continuity
Increased job satisfaction – 3
Increased Midwifery skills – 8
<ul style="list-style-type: none">• To develop and use all midwifery skills
Personal development – 8
<ul style="list-style-type: none">• Desire for greater autonomy and independence (5) challenge, change, more responsibility
Continuity and knowing – 7
<ul style="list-style-type: none">• To know the women they are caring for and be able to provide continuity of care
Rejection of conventional system – 5
<ul style="list-style-type: none">• Hated fragmented obstetric-led care offered by the hospital
Other – 5
<ul style="list-style-type: none">• To practice in community• Experienced as student• Encouraged by caseload midwives• Awareness of evaluation• Geographical

Source questionnaire 1997

The responses from the original midwives indicated a strong rejection of the system of care they were currently providing. This was pictured as being medically orientated, as preventing them from utilising all their midwifery skills and forcing them to provide fragmented care that did not meet the needs of women. Frustrated by this situation they perceived caseload practice as a means of enabling them to develop as midwives, to use all their skills and be able to practice autonomously away from the hospital environment. Promotion was another attraction, as was the sense that they welcomed a challenge and opportunity to work in a new environment with motivated colleagues. The questionnaire response of one midwife succinctly summarised what the group were rejecting:

'Disillusioned with fragmented care in hospital setting. Frustration at not utilising all midwifery skills. Frustrations with the system of care not meeting women's needs. Institutionalised setting. Lethargic midwives entrapped in routinised practices.'

(q.r.pml7)

Midwives who joined caseload practice since its implementation had the opportunity to gain some understanding of what was entailed prior to applying. Their responses to the question were more indicative of its attractions as a service rather than a pilot scheme. Only one respondent mentioned the desire for a challenge, and rejection of the conventional service was implicit in the definitions of what they were seeking rather than raised as explicit points.

Thus, in identifying what they were rejecting, the tone of the first group was quite negative, whilst that of the subsequent midwives in identifying what they were seeking, was more positive, perhaps because once the project was actual rather than theoretical it could be more clearly envisaged.

The main attraction identified by these respondents related to a particular style of care that would enable them to develop both professionally and personally. Caseload practice, which encompassed the ability to hone and utilise all midwifery skills in an autonomous manner, fulfilled the desire to provide continuity of care. This was portrayed as providing a better service to women and increased job satisfaction.

However, the depth of individuals' feelings came across most clearly during the interviews. As one of the original midwives stated:

'I was very, very keen to join this project. It was new, it was innovative, it was challenging, it was being a midwife. It was out of the hospital. I was oppressed, suppressed in the hospital. I wanted (pause) I like challenge and I like change and I couldn't. I was banging my head against a wall in there. And I couldn't see what I'd be doing after I'd rotated again. I could not go and rotate again. I would probably have left the profession, if I'm honest. I was looking for all sorts of things – other things – to do which would give me responsibility and, you know, more money as well.

'To go out as a midwife, having your case load, working within a group, and a partnership, seeing women at their place of choice, usually in the home, and co-ordinating their care from start to finish, taking a few high-risk women, that would involve negotiating with medical staff was, you know, something which seemed to me the only way midwives could function with the, with the training that they've had, really. Personally, my only way that I could move forward.' (i.pm05)

The dissonance expressed between the theoretical model of midwifery expounded during training and that experienced working within the conventional hospital service was reflected by other midwives who gave a similar indication that they were looking to leave midwifery had caseload practice not been implemented. The indication that highly motivated midwives may be leaving the profession because they cannot tolerate working in the conventional style of hospital service has important implications for the staffing of such units.

Post Selection Preparation

Following selection, the midwives were asked to compile 'personal development plans' identifying any training they considered necessary. These were heavily clinically orientated, reflecting the concerns the midwives later expressed about their clinical capabilities in undertaking this form of holistic midwifery. Although the implementation team were aware of the importance of organisational and time management skills, it is probable that specific training on these issues would not have been very effective until the project had commenced; as one midwife noted:

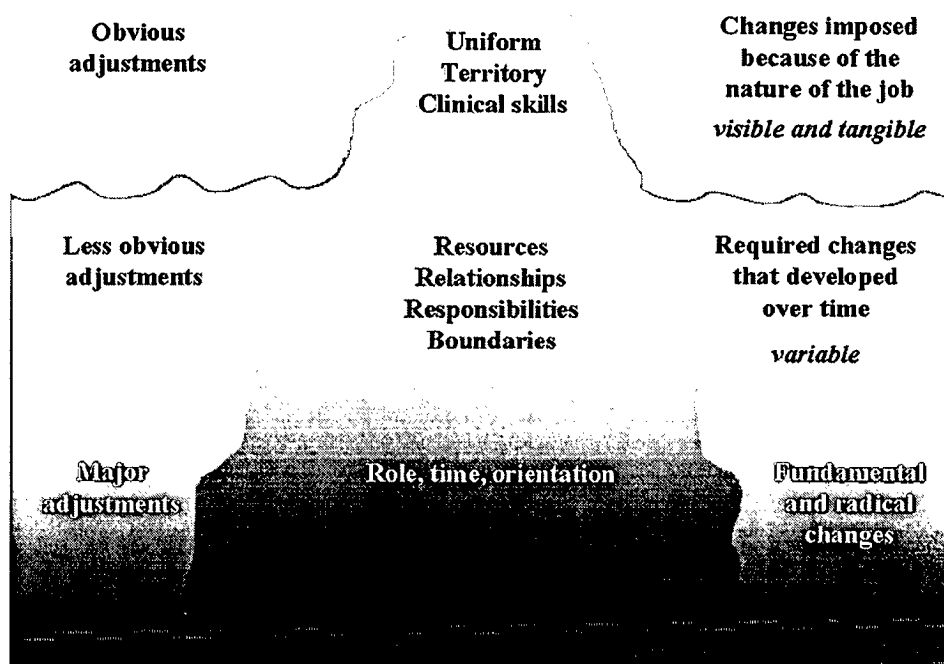
'Even if they had taught us those skills, we didn't realise how important they would be and so wouldn't have taken them on board.' (i.pm22)

Staffing the unit effectively when such a large number of the work force was involved proved a major difficulty in developing an appropriate training programme. This was a concern of the pilot scheme; subsequent individual candidates were more easily released for training and orientation, as required. Once the project had been implemented it proved easier for caseload midwives to attend training sessions as individual workloads were negotiated accordingly.

LEARNING TO BECOME A CASELOAD MIDWIFE

This section focuses on the adaptations identified by the analysis that were demanded of midwives who moved from the conventional service into caseload practice. They are presented here (Figure1) using the analogy of an iceberg in recognition that, whilst several of the changes are highly visible, they are underlain by others of a more fundamental, long-term and less visible nature. The hierarchy suggested in this figure is not an arrangement indicating levels of importance but of development; those at the base are the fundamental challenges of caseload practice that are likely to become established over years rather than months. All the features identified are present within conventional midwifery services but required major adaptations for caseload practice.

Figure 1 The iceberg model of adaptations demanded by caseload midwifery



Obvious Adjustments

Some immediate adaptations were evident to everyone as ‘part of the job’ issues. Caseload midwives wore their own clothes rather than uniform and the work entailed daily practising all aspects of midwifery, in different locations, according to the needs of the women on their caseloads. As visible, tangible features these formed the tip of the metaphorical iceberg.

Much of the initial attention given to the scheme, epitomised by the jokey sketches in the annual hospital Christmas review, focused on the visible signifiers of underlying change such as lack of uniform, their cars, filofaxes and mobile phones; the midwives were reported as:

‘Swanning around with their mobile phones and filofaxes’. (i.jo)

Nevertheless, the implications of making these changes appeared less clearly understood.

Uniform

The midwives elected by majority to wear their own clothes; the debate was reported as being controversial, which partly reflected the recognised issues of uniforms offering security or increased vulnerability in the community.

'It was very strange not being in uniform ... we felt we needed that uniform for extra security or something' (i.pm06)

With experience, they suggested that practice without uniforms enabled them to express their individuality and be seen and related to as a person rather than the more 'anonymous' role of 'the midwife'. It clearly facilitated the flexibility with which their work was incorporated into their lives. The wearing of uniforms (or not) therefore appeared to signify other issues concerned with territory, status, roles and relationships (Jackson 1994; Pride 1995).

Territory

The changes in caseload midwives' territory were multi-dimensional in terms of place, time and organisation of work. In a hospital service the parameters of where, when and how midwives worked were clear, and rotational placements, shifts and protocols offered minimal flexibility. In caseload practice, the parameters were defined by the composition of the midwife's caseload, not the institution and were, initially, undefined.

Few of the midwives had experience of working in the community and several did not know the geography of the area in which they were working. Strangers in a strange locality, initially just 'getting to work' was a daily problem for some:

'My first view was, oh dear me, how am I going to find the houses?' (i.pm03)

'It was really scary in the beginning, I had barely driven.' (i.pm13)

This concern was exacerbated by the fear of being called to a delivery at night before having located the address. Even working within a 'familiar' hospital setting was not straightforward as the two maternity hospitals had different ethos and practices (outlined in Chapter Five). The locus of control had also shifted wherever the midwives worked; no longer hosts within a maternity service they became guests within clients' homes, GPs' surgeries and even the hospitals.

Some of the midwives reported difficulty in adapting to the sense of freedom they felt from no longer having to adhere to a shift pattern of work. Inculcated within the rigid hospital system, the lack of a formal structure to the day initially proved problematic, burdening them with a sense of guilt when not working and causing them to seek out work for themselves:

'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.' (i.pm03)

Such need to 'make busy' has been described in previous research in nursing (Menzies 1970). Adaptation to being available for women was an important aspect of learning to manage the work and is described later in discussing the issues of responsibility, boundaries and use of time. The initial problems centred on learning to use and to 'live with' mobile phones, particularly the belief that they would inevitably be called and the fear that they would miss an important call:

'The concept initially is one of "I will be called". When you are new, you don't realise that you probably won't'. (fg.nm.pm31.'97)

It was important for the midwives to learn how to relax until they were actually called, and to switch off completely when they were 'not available':

'Now I make sure my (caseload) partner gets to meet the women. It takes the pressure off you, I can switch off for the weekend when off'. (i.pm17)

Both uniform and territory were definers of a midwife's role. Thus the changes, with the known being replaced by uncertainty, could have easily generated the loss of a sense of security and of control. However, the midwives were too busy focusing on the clinical adaptations demanded of them to articulate any such disorientation.

Clinical Adaptations

The ability to practice a more comprehensive style of midwifery was cited as an important attraction of the service, but also proved the main source of concern for the midwives in their preparation and the transition period:

'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.' (fg.nm.pm31.'97)

Caseload 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'. Although the ability to practice in this manner was the expected outcome of midwifery training, subsequent experiences within the conventional services had led to a fragmentation of expertise as the midwives were rotated around the different departments, frequently working with medical supervision. The resulting loss of midwifery practical and cognitive skills in such situations was identified by Robinson (1989) (*see* Chapter Two).

The midwives were also required to apply their practice in a variety of different settings, frequently in isolation from other midwifery colleagues or familiar 'reminders', such as visible equipment, that help to influence practice. The concerns expressed differed for those who were experienced in community or hospital practice:

'I was petrified about looking after high risk women, you know, syntocinon and all that. I hadn't got a clue'. (fg.om.pm12.'97)

'The reverse for us was working in the home', (fg.om.pm17.'97)

indicating the disquiet of some when practising away from the 'safety' of the hospital environment.

The manner and speed in which this style of work developed their practice was highlighted by midwives who later entered the project:

'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'. (fg.nm.pm31)

'But it was hard. I mean I'd never worked in the community setting before, working on your own, looking after women out in the community – never seen a home birth until I came up here. You know, there's lots to practice'. (fg.nm.pm29)

Although they found it difficult at first, the requirement to adapt their clinical skills proved one of the important sources of satisfaction for the caseload midwives and is discussed further in Chapter Nine.

Less Obvious Adjustments

The next layers in the iceberg were concerned with factors that were not so visible, their importance being appreciated by the midwives when they reflected on 'the early days

Resource Network

Since this was a pilot scheme for an unfamiliar model of practice the usual knowledge and networks associated with any job had to be built from scratch. Although the midwives had been recruited internally, most had been hospital based and only three were former community midwives with some community-based links already established. Additionally, the caseload project being the focus of some resentment, the midwives appeared to lose the colleague networks available in their previous roles and experienced difficulties with access to basic equipment, such as Guthrie cards, once they no longer 'belonged' to a particular ward. Damage to familiar networks as a result of change was noted by Perkins

(1997); however, in this situation it was as if the caseload midwives' allegiance was perceived as having changed and so, in turn, they were being 'rejected' by their former colleagues.

Working within a diverse population the midwives met a variety of client needs. This challenged them to establish a wide pool of useful knowledge to share with women. The importance of having built up a network of contacts with other professionals and agencies during the first six months was emphasised. The sharing of such knowledge and experiences became an important catalyst for cohesion within the caseload group practices. Once established, such knowledge was then passed on to subsequent midwives as part of their orientation into caseload practice.

Relationships

The nature of caseload practice required that the midwives established deeper working relationships with a wide range of individuals than had been required when practising in the conventional services. Three key categories were apparent: partnership and group, other professional colleagues, and clients and families. Once successfully established the midwives reported gaining great satisfaction from these relationships, the nature of which will be discussed in subsequent chapters. This section is limited to an outline of the adaptations required for successful relationships to become established.

Partnership and Group

Developing good working relationships within the practices was found to be essential. Successful partnerships were cited as being a source of immense satisfaction and help over difficult periods, whilst the group practice became a major source of support which was increasingly appreciated with experience. However, this was not automatic but needed to be worked at, particularly as members of each group did not necessarily know each other very well, despite some having worked together in the conventional services. The focus group of original midwives reflecting on this issue commented:

'At first we tried to be independent, but it doesn't work. You need to know where everyone is and who is off when.' (fg.om.pm13.'97)

(Caseload service) *'is more like a big family than a department'* (fg.om.pm12.'97)

Researcher: 'So what are the important elements that help make a partnership work?'

'Communication'

'Co-operation – give and take, not taking advantage of anyone'

'Respecting each other'

'Trust'
'Similar philosophy'
'People don't have to work the same way but need to have common ground and liaise with women in a similar way – for the women's sake'
(fg.om.'97 pm.12,13,17,19)

One midwife who had experience of four different, and less than ideal, partnerships explained the issue in more detail:

'You actually have to like each other, and you have to be able to communicate effectively – not just communicate – about your social life, your private life, your work life, your love life! – because we work so closely together. I think you should have a certain amount of rapport before you even start working. You really have to sit and talk to each other – about your likes and dislikes. (...) Have some ground rules as to what both of you want out of your work.'

'If you've got confidence in your partner and you both share the same values it doesn't matter so much (being present for delivery) because you feel comfortable that your partner is going to do exactly as you – may be in a different way, but you know, your values are the same.'

'If your partner's going to say "well no, if it was me I wouldn't do that" it causes conflict. Or belittling you with your clients, which does happen. I think that is very unsatisfactory and it can cause a lot of upset. Your patients will tell you, I can assure you of that.'
(o.pm21.'97)

Friendship, though desirable, appeared not to be as essential as mutual respect, trust and a similar philosophy of practice. Fundamental to this, as with all relationships, were good communication skills.

Difficulties with partnership or group relationships proved extremely disruptive and stressful for both the individuals involved and the wider group. Initially, such difficulties required support and assistance from management but with experience the midwives 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 reconstitute (sic) the situation'. (fg.om.pm17.'97)

The midwives 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.'
(fg.om.pm34.'97)

The importance of not ignoring a problem but dealing with issues as they arose emerged as a distinctive feature of caseload practice. Contrasting this with the 'muting' and sense of powerlessness identified in NHS midwives by Kirkham (1999), such issues of control and power are explored further in Chapter Eleven.

Professional Colleagues

An understanding of the responses of the other professionals to caseload practice was presented in Chapter Seven. This section examines the relationships from the perspective of adaptations demanded of new caseload practitioners.

Successful working relationships with other professional colleagues required re-negotiation, particularly in the early days when, as a new and high profile scheme, the project generated resentment amongst colleagues in the conventional service. The project midwives reported feeling hurt by the way colleagues who had been friendly when working together in the conventional service '*changed overnight*' when they moved into caseload practice. Previously friendly faces and sympathetic attitudes were replaced by coolness and, on occasions, a hostile reception.

There were initial difficulties in liaising with hospital-based midwives and both caseload midwives and the women they care for reported feeling ignored by them. In part this was caused by confusion over the role of hospital midwives in the care of caseload clients who had been admitted. However, the caseload midwives were not experienced at communicating the care management requirements of 'their' mothers to midwifery colleagues working on the wards and, at times this was undertaken less than sensitively, generating the perception of orders being given.

The difficulties declined over time, as acceptance and understanding of the model grew, and the caseload midwives became more politically aware and skilled in their ways of communicating. However, a few individuals remained opposed to the scheme and four years into the project new midwives still experienced difficulties:

'I'd go and hide in a corner and ring someone up on my phone' (rather than ask hospital staff). (fg.nm.pm34.'97)

Carving out a new midwifery practice within a very medically dominated service generated some tensions with the obstetric staff. For example, misunderstandings about the role of the senior house officers in relation to midwives led to some aggression on both sides.

Also, all levels of obstetrician were used to supervising the care of 'normal' childbirth and several found difficulty not being involved, particularly with mothers admitted on delivery unit. Thus the caseload midwives had to learn skills in negotiating their 'ground' without provoking resentment or annoyance.

This attitude either developed into a mutual respect, or remained as an acknowledged 'battle' and aggression was superseded by assertiveness on the midwives' part. Many of the doctors developed a respect for the caseload midwives, which they had not accorded to midwives before and which they described as recognition of the 'responsibility' and 'maturity' the midwives demonstrated. This change in attitude was recognised and appreciated by the midwives themselves. A similar change in attitude amongst the GPs was reported, many of whom were initially upset at losing midwifery attachment or feared loss of input in maternity care.

Over time good working relationships were developed with the majority of their professional colleagues. However, in achieving this the midwives had to become politically astute, be sensitive to the responses of others, and be proactive in encouraging the change in attitudes.

Occasionally the midwives perceived insurmountable problems in relationships with particular colleagues. In such cases strategies of avoidance were utilised. Where more 'difficult' colleagues could not be avoided they were considered a 'challenge' and particular midwives would address the resistance experienced on an individual basis in an attempt to overcome it.

Women and Families

In the conventional hospital service the constraints of a shift pattern of working and speedy throughput limited the relationships midwives were able to form with women and their families. In caseload midwifery, prolonged contact and the assumption of responsibility for care encouraged the development of sustained relationships.

Although this was acknowledged by all staff as an attraction of this style of practice, such relationships were not necessarily easy; personality clashes or the demands of particular clients required skilful handling. Each midwife needed to define and establish the type of relationship they felt comfortable with. The midwives initially attempted to provide 'total' care for 'their' mothers, but they quickly recognised this could encourage the development

of a dependency relationship. They learnt to *'back off'* and to share roles more, which also helped them to avoid becoming over-tired.

The transition period was a time when each midwife needed to explore and develop relationships which were very different in nature to those they had established within the conventional services. One midwife suggested that for her, this period had included learning to replace the satisfaction and enjoyment of colleague relationships on the wards with developing relationships with women.

The successful development of these relationships became a fundamental source of satisfaction for the midwives, the nature of which is discussed in detail in subsequent chapters. However, negotiating appropriate relationships when first assuming a caseload involved recognising issues of responsibility and defining boundaries, as discussed below.

Responsibility

In caseload practice the midwife assumed clear and visible midwifery responsibility for a specific number of clients. This generated a sense of pride and duty within the midwives and a sense of 'ownership', frequently articulated as the possessive 'their' client on their caseload; it was also an attitude that could form an important safety feature. The responsibilities assumed were equally concerned with quality and appropriateness of care, and this particularly challenged the midwives when determining when and where referral was required. Although this was part of the recognised responsibility of a midwife, their initial anxieties suggested that this had not been well developed within the conventional service. They worried about the *'grey areas'* between normality and abnormality that could be difficult to define, especially when referral was in conflict with a mother's desires.

Responsibility for personal practice also involved the midwives learning to recognise when to call for assistance. Initially, they tended to assume too much responsibility: for example, working for excessively long periods by providing exclusive care throughout a prolonged labour, or working when sick. The midwives reported feeling guilty in passing on work:

'Guilt is another aspect as you try not to put a burden on the partnership or group'
(fg.om.pm19.'97)

This attitude was noticeably at variance with some hospital midwives who tended to deny or pass on responsibility to others and who readily admitted during informal chats that they

may 'go off sick' if their duty rota conflicted with social arrangements. Recognising that they were not indispensable was an important lesson for the caseload practitioners.

Caseload midwives also learnt to accept responsibility for their caseload colleagues' welfare and practice, something not required within the conventional services. An ethos of mutuality determined that when personally quiet they would still check all was well with their colleagues:

'I plan my work and, if I have a quiet day and think I don't need to go out, I always phone round and just check that the others are OK, haven't been up all night or anything like that'. (fg.om.pm13.'97)

The potential for poor practices to develop was limited by the midwives accepting the need to proactively address such issues, once recognised, either in peer review or group meetings. This was witnessed on occasions, when seeking recourse to relevant research helped resolve conflicting opinions without generating the bad feelings that result from overt criticism. Such discussions were facilitated by the project ethos which supported reflection and learning from each other. It also supported the midwives in taking responsibility for their learning requirements, facilitating them to arrange the various seminars they identified they required.

Boundaries

The necessity to define and re-define their professional and personal boundaries was, perhaps, the most fundamental challenge for the midwives undertaking caseload practice. Within the hospital service, a midwife's boundaries tend to be clearly defined by the institution and refined by the expectations of others (Kirkham 1996, 1999). These midwives learnt that the need to maintain a balance between personal and professional life forced them to define their own boundaries to themselves, their colleagues, and their clients. Although the way they resolved ambiguities were individual, and changed with experience, the data indicated common issues that each midwife needed to address in their transition period.

Professional Boundaries

Challenged by different situations, the midwives had to determine what they considered the role of a midwife to be, and not be, and to ensure mothers' 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 (to other agencies), when to give them the responsibility.' (fg.nm.pm34.'97)

'I had one lass who had a lot of problems – single parent, housing difficulties, her family had disowned her, and I worried about her all the time. She really took over my mind. But there is no magic wand. It all came right for her in the end and I did nothing. But you worry. What if? It all comes with experience.' (fg.nm.pm31.'97)

The midwives also had to recognise clinical boundaries, not only what was considered normal and when to refer, but also how much they could realistically influence outcomes:

'I have redefined my expectations of myself.'
Researcher: 'In what ways?'
'If things went wrong in labour I used to think that it must be my fault and to be upset for them.' (fg.om.pm17.'97)

The deeper relationships they developed with their clients forced the midwives to reassess their level of emotional involvement in the work:

'Now discharge is no longer a huge emotional departure.'
'Now it seems easier to do, we have all set parameters.'
'We have all learnt to say no.' (fg.om.pm12,13&19.'97)

In accepting responsibility for care, the midwives had to learn to be clear about the emotional implications of delivering that care in terms of crisis situations and personal failure. Those who had experience of caring for tragedies such as unexpected intrauterine death, reported finding it easier to cope. They considered the established relationship enabled them to grieve with the family rather than be forced into a purely clinical professional role, the value of which, as a 'distancing technique' has been questioned by Benner (1984) and Mander (2001).

Conversely, in such situations the caseload midwives may be subjected to the force of parental blame, however inappropriate. Occasionally, human error may indicate such blame to be appropriate. Contending with blame when not guilty may be difficult, but coping with the repercussions of having made a mistake could require skilled support. Clearly defining their professional boundaries to themselves, as much as the mothers on their caseload, appeared to be crucial for the midwives.

Personal Boundaries

The midwives also learnt to define personal boundaries. The requirement as a group to provide cover for clients over a 24-hour period invariably caused an intrusion into their personal lives, the mobile phones proving both a symbol and agent of this intrusion. Coming to terms, both physically and psychologically, with more flexible working patterns proved essential, as was learning to cope with the effect of 'availability' arrangements on their social life and domestic relationships. The midwives needed to clearly assess and 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.' (fg.om.pm13.'97)

'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.' (fg.nm.pm34.'97)

The boundaries the midwives drew were highly individual and altered with different mothers and with experience, ranging from tightly defined professional-type to a 'no boundaries, totally open and involved' style. Over time, those with a tendency to the latter moved towards more defined boundaries as they became aware of a need to limit their personal involvement.

Fundamental Changes

In undertaking caseload practice the midwives had to face some major adaptations that challenged their professional and personal roles. In rising to these demands the midwives 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, emerging as major themes of the analysis, are discussed in detail in Chapters Ten, Eleven and Twelve respectively.

THE TRANSITION EXPERIENCE

Much of the literature about change management defines the 'transition state' (Beckhard and Harris 1987) in terms of the organisation and the requirements necessary to effect the desired change. The focus is generally on how to create the 'right' climate (Belasco 1990), involve and capitalise on individual's contributions (Moss Kanter 1994), and plan and manage change effectively (Beckhard and Harris 1987; Broome 1990). Although

espousing ideals to the contrary this is effectively a top down, in anthropological terms, etic approach (Pike 1967; Tyler 1969). What is less apparent in such texts is an understanding of a change process from the perspective of the participants, the emic view. Also, as Perkins (1997) highlighted, change frequently holds emotional costs to those affected yet this is commonly ignored by policy makers.

Movement into caseload practice involved a very radical and fundamental (Beckhard 1992) change for each midwife. Overnight they exchanged a rigidly defined and controlled style of practice for one where there were almost no imposed definitions or control. Such change was experienced by all midwives who undertook caseload practice, whether at the initial start or later once the project had become more established. By electing to move the midwives were clearly attracted by the idea of the model and it has been recognised to be easier to adjust to change that had been chosen rather than imposed (Ford and Walsh 1994). However, although they rejected the conventional systems, it is probable the midwives experienced some 'grief' or bereavement for the lost elements of familiarity in their 'life space' (Murray Parkes 1971), a situation also identified by Marris (1974) and others in change processes.

The movement from the midwives' 'current' state to 'desired' state involved major changes to themselves, their lives and their style of practice. Much of this was poorly articulated and some not recognised by managers or midwives. Although the experience of the changes varied according to the personal characteristics, expectations and previous experiences of each midwife, the themes identified were general and shared, and this time, termed here the 'transition', constituted an intense period of adjustment for everyone. The original group of 20 midwives who were pioneering the development of caseload practice with no precedents within the NHS, described the transition period as lasting approximately 10 months; for subsequent joiners who were able to take guidance and advice from colleagues with experience, the duration was about six months.

As this study focused on a new and untested model of practice for the NHS it is important to try to distinguish those issues linked to change or innovation schemes and those likely to be enduring features of the model. The difficulties experienced in settling into new roles are likely to be greater in a pilot scheme but such schemes are likely to attract those who are motivated or receptive towards change. Nonetheless, similar issues arose both for the initial group of 20 volunteers and those who joined later in the study period, although the latter were able to draw on the experience of their partners and the group.

Those midwives who joined the scheme later did not describe the same level of initial anxieties, but several experienced a 'dip' after an initial period of confidence or 'buzz', before settling in over a longer time period, suggesting that there are aspects of the change in style of practice which are likely to be found in any setting.

The midwives' accounts of this period highlighted something that has a parallel with the phenomenon of 'culture shock', reported by people who move to live within a different culture (Oberg 1960; Hall 1959). The strangeness of everything and element of disorientation experienced can lead to feelings of extreme tiredness, inadequacy and frustration (Furham and Bochner 1986; Gardner 1991). Individuals are commonly described as passing through three stages: anticipation and exhilaration in which a 'high' may be experienced, generated by the over stimulation of an overload of new impressions; frustration, anger and depression then develop as the realities and difficulties of the situation become manifest; those that successfully adapt to their new environment move on to the stage of adjustment and appreciation as they 'come to terms' with their new situation and adopt the values and differences of the new culture (Oberg 1960; Bocher *et al* 1980; Furham and Bochner 1986). Such a movement was clearly described by one of the midwives who joined the scheme towards the end of the study period:

'First 3-4 weeks was fine, it was a doss, good; then went through a real downer, I hated it – this lasted for about 6 months. I missed the company of the ward, the ward environment and colleagues. But as you begin to build up the relationship with your women and deliver those you booked it changes.' (fg.nm.pm31.'97)

Caseload practice was recognised as being very different from conventional midwifery. However, not all the differences were necessarily articulated, with some of the less obvious ones proving fundamental and having a radical effect on the practitioner as an individual and a midwife. Although a parallel with the recognised syndrome of 'culture shock' was apparent, any exhaustion experienced initially by the midwives was more likely to be attributed (by themselves and others) to the hours worked and '*being available*' than a phenomenon of adaptation.

Students who gained experience of caseload midwifery during their training lacked the element of responsibility for the caseload or the control that enables the midwives to make the job work for them. However, it is likely that those who eventually returned as caseload practitioners experienced transition in a different and less radical way. The essence of the transition period was summed up by one midwife as:

'Coming to terms with your fears and expectations and the reality of the job.'
(i.p.m18)

'Making the Job Work for You'

The midwives reported that it was only after they had learnt to make the job work for them as individuals that they could really enjoy working with a caseload. For those who could not achieve this adequately caseload practice became intolerable, so it is important to consider what was meant by the phrase they used.

Although the initial midwives brought a similar training and midwifery experience to the project, their personal characteristics, backgrounds and responsibilities were diverse. No longer subsumed into the anonymous role of 'midwife', caseload practice involved recognition and accommodation of 'the personal'; failure to achieve this could mean the individual being subsumed and subsequently overwhelmed by the work.

Obviously the process by which midwives made the job work for them was individual. Nevertheless, the following common themes emerged:

1. Establishing Acceptable and Accommodating Routines

Because caseload practice involved a blurring of the boundaries between work and leisure, it was vital that individuals negotiated routines that fulfilled all their needs and maintained an acceptable balance in their lifestyle. This involved both structural and organisational features as well as social and emotional ones.

Structural / organisational features involved the general practicalities of their lives; the basic shopping, cleaning and cooking issues of daily living. Those living with partners reported an increase in the help their partners gave at home, particularly with cooking; some midwives employed cleaners. Organising childcare support was highly dependent on individual circumstances, two midwives with supportive family networks reported this easier than in the traditional service whilst others, reliant on the good will of friends, found the situation more problematic.

Maintaining an active social life was reported by some midwives to be easier with a caseload but required both practical and mental adjustments. For example, by keeping the necessary 'gear' in back of the car, one midwife used unexpected quiet periods in the day for an impromptu visit to the local gym; others might visit local friends or go shopping.

Planned social events could be accommodated by negotiation with partner or group concerning cover. For some, the flexibility offered by the mobile phone enabled them to maintain busy social lives even when 'available'; they reported merely restricting distance travelled and alcohol consumption. Others appeared to prefer to stay at home when 'available', maintaining a more structured 'availability' roster within the partnership to ensure uninterrupted enjoyment of social events. Evening classes and day-release courses could be accommodated by forward planning and negotiation within the partnership and group; for some this was easily achieved, whilst others found it more difficult.

The success of such strategies reflected a psychological adaptation to the new lifestyle as the midwives learnt to relax with being 'available' and to recognise that they would not necessarily be called. It also involved learning to adapt to and cope with a work:leisure continuum rather than dichotomy. This phenomenon is discussed further in Chapter Twelve which considers the way caseload midwives were forced to re-conceptualise their time.

2. Strategies of Working

The midwives planned their days in very different ways. Some, acknowledging they were 'morning' people, started work early whilst others rarely commenced visits before late morning; both strategies helped avoid the daily commuter-traffic frustrations. Some midwives refused to undertake 'routine' home visits during the evening whilst others preferred this arrangement. One midwife aimed to undertake all her antenatal visits on a Monday so as to be able to plan the rest of the week with some 'feel' about the potential workload. Another organised all her planned work into three long days, leaving the others days free and able to respond to the unplanned needs of her women. Such strategies, aided by an attitude of flexibility and rejection of a set format for antenatal and postnatal visits, helped encourage a response to need rather than routine.

Successful individual strategies also involved negotiating appropriate ways of working with their partner; these included close communication and developing compatible ways of working, as discussed previously. As one midwife noted, a successful relationship meant that when she was unable to be present she had confidence in the way her partner would care for her women. This supported the relationships and confidence she had developed rather than cause confusion and engender distrust by presenting conflicting ideas.

3. Being in Control

The idea of having learnt to be in control involved developing a pro-active rather than reactive or passive approach to the work. It necessitated accepting responsibility and enjoying it rather than finding it burdensome. As well as maintaining a high clinical standard this encompassed organisational and time management skills and accepting responsibility for personal professional development. Learning to negotiate with professional colleagues, developing communication skills that were assertive rather than aggressive, proved another key factor.

The sense and reality of being in control was an iterative process, as experience and confidence built on and reinforced each other. The supportive philosophy of the Midwifery Development Unit which helped oversee the project was important in encouraging an atmosphere of learning and development rather than blame and discipline. Group peer review discussions were fundamental to this mechanism and, although regular formal sessions were not achieved as planned, informal discussions appeared commonplace.

Although the midwives considered it was important to develop a sense of being in control, they also noted how they needed to learn not to fight the system. As one noted, during a busy period *'it was no point in hoping the phone would not ring, sod's law it would'*. At these times one needed to rely on the support from colleagues and know that a quiet spell would come shortly. Coping with the peaks and troughs of the work, *'playing the system'* and *'making it work for you'* were fundamental requirements for successful caseload practice.

CONCLUSION

From this analysis it can be understood that caseload midwifery did not constitute merely the transfer of midwifery skills into a different setting but involved a major adjustment to each practitioner's understanding of what it means to be a midwife. The nature of midwifery, previously structured by institutional practices, required re-defining by individuals – to themselves and to others. The analysis of the adaptations demanded by caseload midwifery provides an articulation of the principles of 'responsibility' and 'autonomy' that are fundamental to caseload practice. It also shows how these differ from the conventional services.

Responsibility did not relate purely to issues of clinical practice, although these were central to the midwives work and, being clearly defined by holding a recognised 'caseload', developed in a manner not encouraged by the conventional service. It also encompassed accepting responsibility for colleagues' practice as well as their own, and involved issues of wellbeing, both personal and colleagues, in recognising when help was required in times of tiredness, stress or illness.

Autonomy was seen not as isolationism but in the establishment of effective relationships that supported care provision for mothers. For such provision to be delivered where and when required, effective autonomous practice necessitated the midwives 'owning' their time and learning to re-define a work:leisure dichotomy of lifestyle, themes which are developed further in Chapter Twelve.

The profile of the caseload midwives, presented initially, suggests these practitioners were not substantially different from other groups of midwives (Sandall 1998). All except one had nursing backgrounds, so were trained in institutionalised care. However, their profound rejection of institutionalised midwifery, suggests the profession may be losing such practitioners where alternative styles of practice are unavailable. The subsequent experiences of these midwives undertaking caseload practice, and how this altered their orientation to their work, forms the focus of the following chapter.

Chapter Nine

PRACTISING 'REAL MIDWIFERY'

THE MEANING OF CASELOAD PRACTICE FOR MIDWIVES

INTRODUCTION

This chapter focuses on what it meant to the midwives to undertake caseload practice and why, despite the problems encountered and difficulties experienced, they very clearly preferred working this way than in the conventional service. Although focusing on caseload practice, the analysis again illuminates differences between caseload and conventional practice and the manner in which the organisation of practice influences midwifery work.

Many of the issues identified in the preceding chapter are explored further as the ways in which caseload midwifery changed practitioners' relationship and attitudes towards their work and their profession are discussed. This forms the bottom layer of the iceberg model of adaptations (Figure 1).

'REAL MIDWIFERY'

When considering what carrying a personal caseload meant for the midwives, the most striking feature was the enormous job satisfaction they expressed and their consideration that this style of service enabled them to practice what they defined as '*real midwifery*'. The implication was that this style of working was both very different, and superior, to that they had experienced within the conventional services.

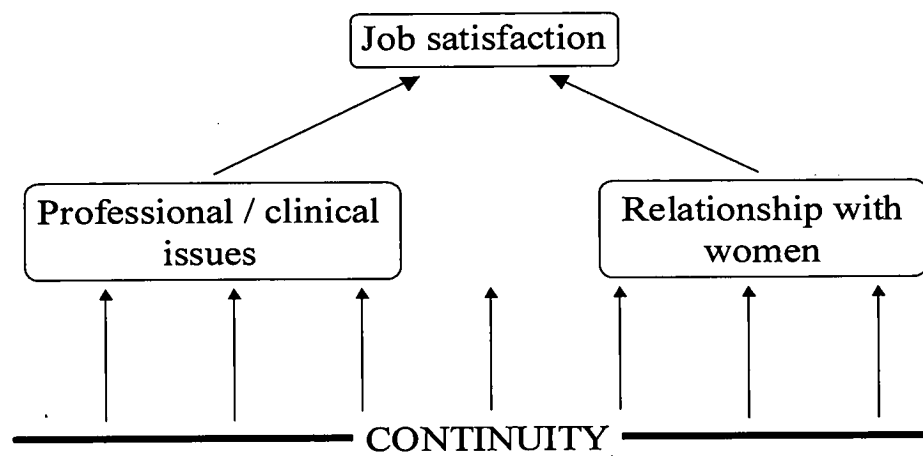
'We had a learning curve that hit the roof, it was when I learnt to be a midwife. In the hospital I didn't know how; it was only when I went into the homes and was asked a question. I was desperate!'
(fg.om.pm 34.'97)

Such comments raise questions concerning the nature of this '*real midwifery*' and the nature of the '*midwifery*' they had practised within the conventional services.

In seeking to define what was so special about this style of midwifery, the sources of satisfaction mentioned during interviews were analysed. These were clearly defined in two

areas: professional and clinical practice, and the relationships they formed with women and their families. An underlying theme was the issue of continuity, which was fundamental to the development of the two areas identified, as illustrated in Figure 2.

Figure 2 Sources of satisfaction for caseload midwives



PROFESSIONAL ISSUES

The sources of satisfaction grouped in this area included issues relating to their clinical midwifery practice, professional relationships with colleagues of different disciplines, and relationship to the midwifery profession. These are considered in detail below.

Clinical Midwifery

Midwives dissatisfaction with the restrictions to and fragmentation of their role have been highlighted by many (Robinson *et al* 1983; Robinson 1989, 1990; Garcia *et al* 1985; Curran 1986), and the reasons leading to this situation outlined in Chapter Two. Historical perspectives and reviews such as that by Green *et al* (1998) suggest the way a service is organised radically affects the way midwives are able to practice. Individual caseload practice offered a model of care that was similar to that experienced by the original ‘handywoman’ or more traditional community midwifery service (Leap and Hunter 1993). Although working 60-90 years later, these midwives clearly found such a model facilitated rather than restricted their practice in two key areas: being required to use all their skills, and to continually adapt and develop them.

Frequent Exposure to All Aspects of Midwifery

In choosing to move into caseload practice, the midwives had cited as reasons stagnation and their inability to ‘*practice fully as a midwife*’ in the conventional service. In the hospital

service their slow rotation around the different departments encouraged a honing of specialist skills, such as those required in delivery unit or in clinic, rather than the development of all areas of practice. Caseload practice forced the midwives to hone all their basic clinical skills and, using these on an almost daily basis, they quickly felt competent and confident in an 'all round' general sense.

Midwifery practice was not confined to working with uncomplicated pregnancies and birth. Nevertheless, the conventional community service focused predominantly on low risk antenatal care and postnatal domiciliary care with a small input in low-risk intrapartum care on the 'domino' scheme and very few home births. In contrast, carrying a mixture of both high and low risk women on their caseload, project midwives continued to be exposed to complicated clinical situations and were able to maintain their confidence and expertise in the required care.

The different skills required by the hospital and community services respectively were both needed and so both developed by this model of caseload practice. The practitioners recognised the very 'steep learning curve' they initially faced but they spoke of this positively and as a challenge they welcomed:

'Accelerated my learning – if I had remained in hospital I think it would have taken me five times longer to have reached this level of knowledge and skills.'

'You feel you are a midwife – after a while of working this way there will be very little that you don't know about'. (fg.nm.'97)

Development of Midwifery Knowledge and Skills

Assuming responsibility for a variety of high and low risk cases enabled the midwives to develop their practice in three ways:

1. Wider Exposure to New Situations

The midwives were exposed to a variety of new situations, for example requests for home waterbirths or a vaginal breech delivery. To enable them to be able to respond appropriately, their learning requirements were supported in a number of ways:

- 24-hour access to experienced midwives supporting the project, who formed 'The Action Group'.
- The Lecturer-Practitioner attached to the project who facilitated both theoretical and practical education, as identified by the midwives, and accompanied inexperienced midwives for home deliveries.

- Peer group support – both informal on a 24-hour basis from their partners and other caseload practitioners, and as a more formal mechanism within the groups for examining practice.
- A managerial ethos that aimed to be supportive rather than dictatorial, favouring supervisory as opposed to disciplinary guidance. Thus investigatory procedures for mistakes were made with the aim of correction by learning rather than punishment.

This aided the development of an ethos of practice that recognised uncertainty as acceptable, and supported individuals in seeking the required knowledge or skill; an ethos that Schön (1983) suggested promoted a new form of reflective professionalism. In the majority of situations the autonomy and flexibility offered by caseload practice enabled the midwives to attend prearranged seminars or visit professional libraries as part of their working day.

This situation was in contrast to the conventional service where certain skills were honed by particular individuals rather than all. There was a clearly defined '*queen*' of waterbirths in one unit and only two community midwives were recognised to positively facilitate homebirths. The confining of 'specialised' skills was due to a variety of limiting factors: minimal need; midwives reluctance to actively seek appropriate training, particularly if undertaken at personal expense and time; and a limited budget to support such training.

Within the hospitals, immediate information needs were easily met by seeking advice from a variety of medical staff or midwifery colleagues. Personal experience highlighted a number of full-time midwives who were unable to respond to relatively basic queries. The indications were of a significant proportion of midwives who were not keeping 'up to date' with their clinical practice and who relied on the doctors as a means of accessing relevant knowledge. These midwives' immediate needs were met but longer term practice development appeared extremely weak, limited by poor resources and low personal motivation.

In contrast caseload practice demanded a high level of practice, with individuals easily identified if problems arose. In accepting responsibility for care, caseload midwives were seen to accept responsibility for their learning needs in a manner not facilitated by conventional practice, where responsibility was limited to a relatively short time span, or shift. The contrast was highlighted by one caseload practitioner on returning to work in the conventional service:

'Caseload practice keeps you up there (on top of things), you don't have time to vegetate. If anything came up that you didn't understand you immediately looked it up. Now (shrugging as this was said) you just ask a registrar or SHO.' (i.pm08.3)

The implication was that in the hospital if something arose which the midwives did not fully understand there was no real need for them to bother too much about it; they just needed to check it out with the doctors – who took responsibility for patient treatment.

2. Feedback and Reflection

Development of practice was facilitated through providing continuity of care. By following through care the midwives were able to see the outcomes and assess decisions that were made. Continuity made an important 'feedback loop' for evaluation of care provided, which included a safety aspect:

'It makes you appreciate the value of today's activity on tomorrow's care. You can see the results of what you do today. If you miss something in hospital it is not so important' (inferring the expectation that someone else will pick it up). (fg.nm.'97)

One student described how the ability to follow up and constantly assess the impact of advice given enabled her to change advice to meet individuals' needs and that she could learn from this and build confidence in her practice; for example: having observed the subsequent healing of a perineum she had sutured, she noted with confidence *'I now know it will not fall apart!'*

During participant observation of caseload midwives' practice, reflection on advice and care given was seen to be undertaken in conjunction with the mother rather than as a personal reflection on practice. This was most obvious during postnatal visits where discussions about infant feeding or wound healing were frequently grounded in a time-and-knowledge frame that both mother and midwife shared; the current situation was related to experiences and changes over the preceding days. This shared knowledge offered advantages in terms of appropriateness and speed of care delivery in the context of a mutually trusting relationship; as such, an iterative process was apparent in the delivery of care.

Such benefits were not necessarily confined to the current episode. One experienced caseload midwife on a postnatal visit was observed to relate current difficulties to the woman's experiences with her previous baby; continuity in this situation had been provided over two childbearing experiences. The midwife's calm observation that the mother had experienced a

similar problem last time and how it had resolved spontaneously, appeared to immensely reassure the mother who immediately agreed and visibly relaxed.

The midwives clearly appreciated the ability to ensure the care they provided was suitable and refine it appropriately, commenting that one of the frustrations of conventional midwifery was the conflict of advice given by colleagues on subsequent shifts:

'I spent the whole afternoon teaching someone to breastfeed and I came in the next day to find someone had given 2 bottles overnight!' (i.pm083)

3. Adaptation and Application

The caseload midwives noted how, in developing their skills, they also had to learn to adapt and apply these to different situations, a requirement that ensured their practice was dictated by need rather than rote:

'It's an ongoing process, you have got to keep changing as you go on. New women on your caseload and you have to readapt to their different needs.' (fg.nm.'97)

This gave constant variety to the work, preventing the stagnation or boredom that some complained of in the hospital and had been noted by Schön (1983:60,61) to contribute towards 'burnout'.

'I was stagnating there completely – whereas at least this job you're continually meeting new challenges all the time in your daily round. Just different sort of pregnancies, sort of different people, different social backgrounds. You know, you get involved with many more disciplines – like social workers, health visitors and doctors. It's a far more professional way to work.' (i.pm23.2)

Nevertheless, the midwives also perceived that, despite the enormous 'learning curve' demanded by caseload practice, they were losing some previously acquired skills. For example, one noted how few perineal suturings she undertook as knowing the women appeared to reduce perineal trauma at delivery. This perception was confirmed when a reduction in perineal damage was identified in both evaluations (McCourt and Page 1996; Beake *et al* 2001). Recognition of competencies requiring specific input to be maintained form an important feature for in-service training needs of caseload practitioners.

It became clear from the analysis that this model of practice facilitated the development of the more reflective 'expert' practitioners described by Schön (1983) and Benner (1984). Expertise in this study is defined as the skilled application of theoretical and experiential knowledge as opposed to a judgement concerning merely the extent of that knowledge.

Described by Schön (1983) as combining a 'knowing-in-action' with 'reflecting-in-action', such expertise would encompass both the 'art' and 'science' of midwifery. In arguing caseload practice is more conducive to this development than hospital practice, Benner's original work which proposed a typology of practical knowledge, offered useful insights (1984).

Using the Dreyfus model of skill acquisition, Benner suggested that practitioners can progress through five levels of competency, from novice to expert, a movement which necessitates three changes:

- From a reliance on abstract principles to concrete experience and the creation of '*paradigm cases*' which were referred back to offering guidance for current situations.
- Situations are perceived not as a compilation of bits but a complete whole in which only parts are relevant.
- The practitioner is no longer a detached observer but an involved performer, engaged in the situation.

Thus the expert practitioner grasps each situation as a whole, draws on past concrete rather than theoretical situations, and quickly identifies the core characteristics of a problem.

Although criticised for basing her work on research that had not previously been applied to nursing, poorly detailing her methodology and failing to explicate how such expertise may be achieved, Benner's ideas proved seminal to nursing philosophy and have been developed and expanded by subsequent research (Benner *et al* 1996), although the core notions of expertise remain. However, this later work, developing the ideas of expertise from a study of nursing in intensive care units, offers less insight to an understanding of caseload midwifery practice.

The argument presented here does not suggest an inevitability; rather that the organisational features of autonomy, responsibility and continuity which constituted caseload practice, generated a frame within which practitioners were both motivated and stimulated to achieve the movement towards such an expertise in midwifery practice. Some of the implications for and about this different form of professional practitioner will be discussed in Chapters Ten and Eleven.

In addition to the satisfaction expressed concerning their clinical work, positive changes in the midwives' professional relationships also contributed towards their enjoyment of caseload practice.

Professional Relationships

When considering the sources of satisfaction they found in undertaking caseload practice, the midwives identified three areas that are considered under the term 'professional relationships': those formed with their caseload colleagues, with other professionals, and with midwifery as an occupation *per se*. Relationships they formed with mothers are considered as a separate category.

Caseload Colleagues

The sense of solidarity and peer support the caseload midwives experienced amongst themselves during the difficult early days of implementing the project undoubtedly generated a degree of cohesion that was a feature of a pilot scheme:

A: 'At times you got very very low but the solidarity was there!'

B: 'When started there were three groups but it was like one bunch; now there are three groups. eg. if I was on DU and I saw you, C, I would get some help.'

C: 'Yes, it was always such a relief when you saw another (project midwife) round the corner, you felt such a relief.' (fg.om.'97)

Some of the midwives noted how they had developed lasting friendships with their colleagues. However, the satisfaction gained was not confined to working with friends but, more importantly, with like-minded midwives, forming an enduring feature of the caseload model. Although encompassing a wide diversity of personalities and experiences, the midwives shared a similar ethos of practice:

'It's like going to heaven being with midwives that work the same way, who are enthusiastic. I felt this big cloud has lifted!' (fg.om.'97)

'The support for each other was tremendous. The calibre of people I work with is – I've never experienced it before and I probably never will.'

'I suppose that to be realistic, liking and having somewhat of a friendship with your partner, does help.'

'After a year you can really reap the rewards from a good partnership.' (all from i.pm16.2)

'We are like-minded folk and it's a friendship, and it's just lovely sometimes to be with each other; we like being with each other and we get a lot from each other and it's no other environment I've ever worked in where I've had that.' (i.pm18)

'Perhaps the closeness we experienced in the group, maybe the major factor was personalities - that we all shared the same philosophy of care.' (i.pm20.2)

This was contrasted with the conventional services where they commented that:

'a lot of midwives are working with people who have lost or are lacking motivation.'

(fg.om'97)

It is pertinent to note that most of the caseload midwives had previously worked together in the conventional service but had not achieved a sense of solidarity, suggesting this to be a feature facilitated by a particular organisation of practice rather than the personal characteristics of individuals.

Nevertheless, such positive relationships were not automatic, but needed to be worked at. Where problems did develop these could be extremely disruptive so needed to be confronted and worked through. The midwives had to accept responsibility for sorting out difficulties rather than avoid them, as was reported to be the tendency in the hospital. They also needed to accept responsibility for their colleagues' practice as this system held the potential for the midwives developing inappropriate or slightly risky practices. On occasions, when observing group practice meetings, such support through constructive questioning and supportive guidance rather than criticism was observed.

The giving and receiving of such support was reported as being poorly developed in the conventional service. Guidance might be forthcoming from supportive senior midwives; however, tales of back biting and criticism were not uncommon, forms of 'horizontal violence' (Leap 1997; Kirkham 1999) that were highlighted in Chapter Five. In the event of a misfortune, such as a still birth, the midwives reported feeling extremely unsupported in the hospital, and described a sense of ostracism by their colleagues akin to a fear of 'contamination'.

This culture of fear of contamination was at complete variance to caseload practice where the midwives reported being extremely supported by colleagues when dealing with a misfortune, likened to support from a family:

'You gain from your colleagues' practice - join in the joys and sorrows. It is more of a family atmosphere, there is more sharing, of information and experiences.'

(i.pm20.2)

It would be mistaken to imply that colleague relationships within the conventional service were necessarily unsupportive and dysfunctional, although at times this was apparent. Indeed, midwives working in the hospital obviously found pleasure in working with particular colleagues and, when very busy, a team spirit approach to the work was both observed and personally experienced. However, such camaraderie was more superficial

than fundamental, a depth of unease and discontent being apparent when talking to individuals. As one E grade midwife noted when talking about relationships within the midwifery staffing:

'You get a lot of back-biting, gossiping, foolish chat, you know. Really foolish, indiscreet, unhelpful, you know, all that sort of thing. It just boils down to the sort of chats you'd expect to hear between sort of, you know, neighbours that just didn't like each other.' (i.hmE.01)

Similar attitudes were reported in the community service and were contrasted by one student with the attitude they had experienced working in the caseload project:

'...the thing that I just notice so much difference between (caseload midwives) and community. And I actually said that to one of the community midwives the other day. In the community I would think that some of them would have an argument every single morning. That's awful for me in the morning between 8.30 and 9.30 there's always (so much friction) – it's usually one of about 3 people – and it's just horrible and I don't mean to go on about them because it's not really what you're ... but it is horrible.

Well, I mean, it's awful and I was in there the other morning. And they came and there was the fighting, the tantrum and someone walked out. And I was talking to (names a community midwife) a couple of weeks ago and I said I go to the caseload project and if someone is really tired or really bitchy – and I wouldn't say really bitchy but really tired, had a lousy time – I said they always get a hug from your colleagues. There's a really nice atmosphere in the caseload project. There's lots of hugs, there's lots of caring, there's lots of saying – and I heard it today – "you sound really tired. I think you need to go off-call tonight, switch your phone over to me and you can take one of my nights later on". The support is lovely between caseload midwives.' And I said to X "I dare you to go to the community midwives' office one morning and give one of them a hug". And she just cracked up laughing because she said it would never happen and they just wouldn't know how to cope with it if she did.' (i.st.m)

The development of such a degree of support and caring formed an important feature of caseload practice and denies the perception that caseload midwifery encourages an 'individual' and isolated approach to work. Such potential may be present but was identified by the midwives as compromising the sustainability of working this way.

Professional Colleagues

The perceptions and responses of their professional colleagues towards caseload practice were presented in Chapter Seven, and the adaptations to these relationships demanded of the caseload midwives outlined in Chapter Eight. This section highlights the subsequent development of a different form of relationship, based on respect.

Although the project midwives encountered some difficulties and even hostility from their colleagues working in other parts of the maternity service, as time passed in many instances this changed and more positive attitudes developed. The midwives feeling noted and respected was, by implication, in contrast to the anonymity previously experienced working in the conventional service. The recognition they gained was highly valued and proved another source of professional satisfaction:

'Recognition for professionalism – I found I got that in the caseload project but not in the hospital.'

'... the doctors may say "good on you, that was a good decision".'

'Recognition that the decisions you made were the correct ones and that you acted correctly – by your medical colleagues.' (i.pm08.3)

A: 'I must say that, coming from community where I had had no contact with doctors, I found I had a better relationship with the obstetricians working with a caseload.'

B: '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.' (fg.om.'97)

However, the caseload midwives also recognised a need to be assertive rather than aggressive, and that there had initially been problems with some of their colleagues.

A: 'In the beginning we would get people's backs up'

B: 'there were certainly some midwives who got above themselves and the backlash fell on the rest of us. Now people know us so well and I don't think we will be judged by the behaviour of individuals.' (fg.om.'97)

Indeed the image initially projected of overconfidence and cockiness had been commented on by both medical and midwifery staff, although some suggested that such attitudes covered apprehension.

Attitude to Work and the Profession

Although this was not clearly articulated by the midwives, it became obvious that they developed a different attitude towards their work and that this proved a source of satisfaction to some. They enjoyed being midwives, practicing '*real midwifery*' as they called it, and perceiving they were good at it. As one noted having returned to the conventional service:

'I am not as proud of myself now. I don't think I do as good a job - not that I am not good at my job but that I am not able to do it as well.' (i.pm08.3)

This issue has important implications for the retention of midwives and future sustainability of the model. It is considered further when discussing the way the midwives

redefined their role, their 'involvement of self', and the new form of professionalism developed, in Chapters Ten and Eleven.

It may be argued that these midwives constituted a particularly motivated and enthusiastic group and that the issues identified in this analysis are more characteristics of the individuals than the model. However, apart from four later members, they were all working together in the conventional service prior to the project, not 'hand picked' from outside, and were not recognised as 'exceptional' midwives. What became apparent was the importance of the combination of factors that worked together to create the positive atmosphere. Willingness and enthusiasm is clearly important but the right environment is required to nurture people's capacity and motivation. The particular ethos of practice, organisation of care, and types of support that were features of this model brought such factors together and enabled the midwives to develop in a manner not facilitated by the conventional service.

RELATIONSHIPS WITH WOMEN

The second main theme which emerged as contributing to the midwives' job satisfaction involved the relationship they were able to form with mothers and their families on their caseload. Many other studies have similarly noted the positive difference in the relationships midwives working in continuity schemes found they were able to form with women (Stock and Wraight 1993; Walsh 1999). However, this appears to be more significant than just a nicety, an 'icing on the cake' type issue inferred by Allen *et al* (1997).

The potential psychological implications of this relationship for mothers is indicated by the way they can remember those who cared for them during childbirth long after the event (Simkin 1991; Wilkins 1993, 2000). It was as if the experience was burnt into their memory, irrespective of whether the care was kind or harsh. That the relationship might hold benefit for midwives themselves was highlighted by Sandall (1997) who identified a link between their ability to develop meaningful relationships with women and the avoidance of stress and burnout.

Nevertheless, it would be naive to assume that all midwife:mother relationships would be of this 'meaningful' nature. Analysis of the relationships the midwives talked about, and

noted during observation of home visits with the midwives, identified three main typologies. These are discussed under the terms:

- The professional-friend.
- The professional.
- The '*demanding*' client.

However, it must be acknowledged that this typology is an analytical device. Relationships change, and the characteristics defined as discrete are more realistically a variety of elements which may alter to a greater or lesser extent, in each relationship.

The Professional-Friend

The 'professional-friend' relationship formed with women was obviously central to the satisfaction expressed by the midwives. The term used is drawn from the work of Pairman, most helpfully her 2000 contribution, and discussions such as Kennedy (1995), Walsh (1999) and Wilkins (2000). It acknowledges that the relationship was established for a particular purpose, the delivery of a service required by the mother which was self-limiting in time, yet it encompassed a warmth and mutuality more commonly associated with personal friends. Nevertheless, the expectation of a high quality 'professional' service, as discussed by Schön (1983), remained the foundation of the relationship.

In analysing the characteristics of this relationship several different features became apparent; warmth, respect, the involvement of self for both parties, reciprocity and balance were the main themes identified. The midwives spoke with genuine warmth about 'their' mothers, and talked with a very real concern about the problems the women might have. A sense of 'ownership' was apparent in the attitudes the midwives expressed, although this related to their assumption of responsibility for care than any sense of exclusivity over care provision. The ownership was also apparently mutual, with mothers observed to talk about 'their' midwife and the midwives noting the caring way some mothers and their families had responded to them. An awareness of the midwife's comfort, their preferences in refreshments, and genuinely making them feel welcome in their home and a part of their life at this time, were frequently spoken about.

Such seemingly genuine mutuality was apparent during observation of the midwives' working practices. It was particularly noticed in the greetings and farewells made, the considerate questions posed, and displays of remembered information, all demonstrated as much by the mother as the midwife. It was also witnessed by a researcher working in

another arm of the wider evaluation, who commented on how much this must enhance the midwives' self-esteem.

A strong sense developed that the midwives themselves gained from the relationship, which involved far more than a one-way giving of information, advice and support. Reciprocity appeared to form an important element, and the structure of the relationship was clearly more balanced than those observed in the conventional hospital service where inequality predominated. This inequality related to a power differential mainly generated by the valuation placed on professional knowledge (Foucault 1980) and the vulnerability of mothers as 'guests' in the service facilities. The contrasting features of the predominant types of relationships formed in these two models of service delivery are outlined in Figures 3a and 3b respectively.

Figure 3a Hospital-midwife-mother relationship

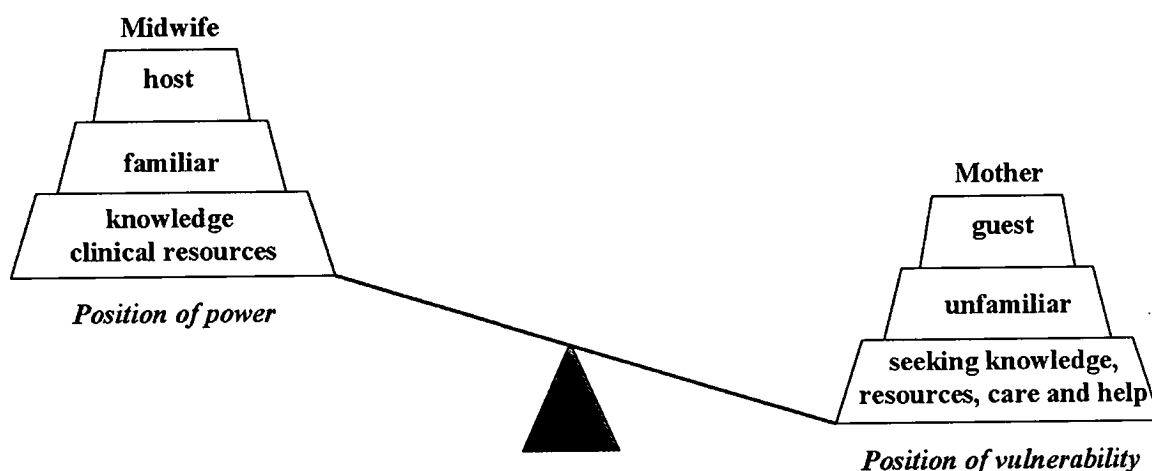
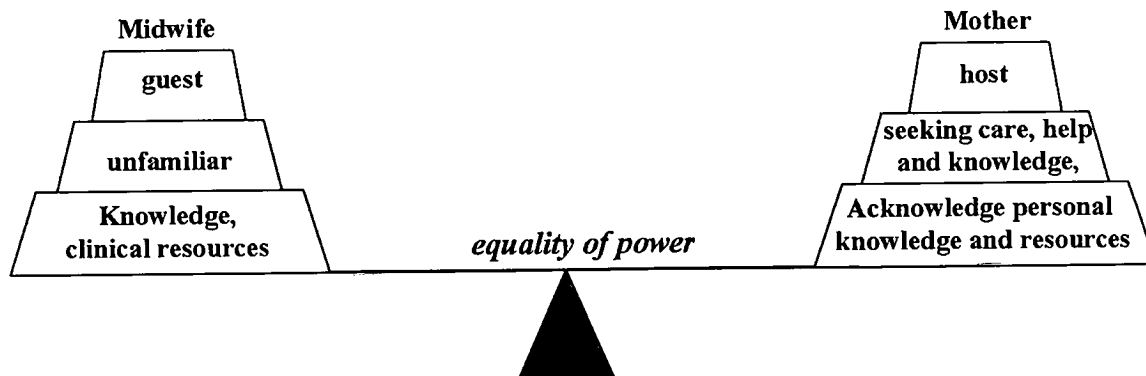


Figure 3b Caseload-midwife-mother relationship



One caseload midwife talked of an 'equilibrium' in the relationship, formed partly by a mutual respect and sense of equality. Such respect involved not only the midwife

understanding the mother but also the mother understanding the midwife; the person of midwife, not just the role, was acknowledged and respected. The equality noted pertains to issues of control and power.

The themes of 'involvement of self' and 'reciprocity', and issues concerning control and power emerged as fundamental to caseload practice and so are considered in detail in subsequent chapters.

The Professional

Clearly not all midwife-mother relationships develop into the 'professional friend' outlined above. The second typology identified was similar to that expected in more traditional 'professional' roles, with clearly defined boundaries and limited personal involvement of either mother or midwife. Nevertheless, it was radically different from such traditional relationships in that its nature was usually guided by the mother, more occasionally by the midwife. In this sense it remained woman-centered.

The boundaries might be defined either physically and / or psychologically; either way the mother limited the midwife's involvement in their life. Occasionally the midwives reported that mothers did not want to receive antenatal visits at home, preferring the more anonymous location of GP surgery or hospital clinic, perhaps to avoid unnecessary intrusion into their private space. However, the midwives also recognised that some mothers sought the social element of visits held in a communal setting. More commonly, mothers appeared to just place less importance on the relationship with the midwife.

Such a relationship was considered relatively easy for the midwives but obviously gave them less satisfaction. They talked of the mothers requiring, and they providing, a professional service; they would visit and the relationship was pleasant and friendly but 'no more'. One midwife referred to this as '*the semi-relationship of the community midwife*', likening it to their experiences in that service where '*no great relationship*' was formed.

Researcher: 'Talk to me about the "professional" relationship - the one you call professional. What's that like?'

'It's fine. Say, if you go into a woman's home you do all her care, you provide her with all the care, all the information she wants throughout the pregnancy. But you never get past sort of, if you like, getting to know her. And sometimes they don't want you to go to their homes so you never get to see them in their own environment or you

never get to see the other children with them or whatever. They just come and go to my antenatal check. That's it, and I'm out. (i.pm07.2)

During observation of their practice, visits were witnessed where the relationship between mother and midwife appeared to come into this 'professional' category. Although a high standard of care was exhibited, it was clear that there was minimal involvement of self by either mother or midwife. Communication, although friendly, had a degree of reserve on either or both sides. The women determined their level of involvement by the questions asked and depth of response to the midwife's queries; the midwife by the degree to which she picked up on specific cues or handled requests. Nevertheless, this did not involve the type of 'verbal asepsis' identified by Kirkham (1989:125); midwives were seen to be responsive and communicative, but held back on their 'involvement of self'.

This form of relationship was also witnessed when working with the community midwives, where it appeared to be the norm, and from both personal experience and observation, formed the norm for relationships established in the conventional hospital service. The impression was that, on occasions, the caseload midwives reverted back to it, preferring it and choosing to maintain rather guarded boundaries, in situations where they had difficulty. For example: where a mother or family tried to involve the midwife in problems that were not her remit and she had advised accordingly, as was observed on two separate occasions, with different midwives.

The 'Demanding' Client

The third typology relates to those mothers the midwives found it difficult to work with, particularly in the beginning. The term 'demanding' was used by the midwives in the earlier stages of the implementation, and also featured as a response in the questionnaire. The midwives reported that some mothers held inappropriate expectations of the service offered, considering the 24-hour availability gave them license to phone the midwife at 2am concerning a non-urgent issue, despite being advised to the contrary. Termed by one of the midwives as 'the users and abusers', these mothers often came from socially advantaged groups, a situation which was reported to irritate the midwives who considered they had more 'needing' mothers on their caseload. Although such 'demanding' mothers would also be present in the conventional service, their demands would be spread over a number of practitioners; rarely would one individual remain the constant focus; learning to cope with this situation proved another skill to hone.

With experience the midwives became more adept at working with mothers and families who made 'excessive' demands on the service, developing strategies for coping that included:

- Defining clearly to the women appropriate expectations of their role as midwife, and appropriate occasions and timing to call them.
- Being assertive about the appointment time and not constantly changing it for the convenience of the mother.
- Maintaining a 'professional' relationship (*see above*) and visiting only when needed. This involved '*Not dropping in for coffee*' and '*selective postnatal visiting*' (*see Glossary*).
- Actively involving other health professionals more, such as the GP with health queries and problems.

However, enforcing this was occasionally very difficult. In such situations the midwives reported they relied on the advice and support of their colleagues, as they tried to define the boundaries to create an appropriate relationship that met the mother's needs without exhausting the midwife.

Avoiding Dependency

In using the term '*demanding*' the midwives were not referring to the more needy mothers on their caseload. Sympathetic to the needs of those who were from socially deprived backgrounds, the caseload midwives also identified the potential for the development of dependency relationships and learnt to define realistic expectations of their role to themselves and the mothers.

'A lot of people – they'd put an awful lot on you. They'd see you as not just a midwife but as a social worker, housing officer, maybe even, you know, getting things like benefits sorted out for them.' (i.pm22.2)

A: *'Some women want you to take over.'*

B: *'We recognised this as a problem early on and have backed off.'*

Researcher: *'How?'*

B: *'Defining your role with them from the outset, eg. I am not involved in getting your new house, although I will write a support letter.'* (fg.om.'97)

The midwives talked about '*educating*' the women, encouraging them '*to be responsible for themselves*', and no longer using the midwife as a '*crutch*'. Once the boundaries were agreed and a more balanced relationship formed, the midwives clearly appreciated supporting such women. They talked about:

'... empowering women who otherwise would have no choice or power.'
'speaking up for women who otherwise would have no one, eg. the Somali ladies.'

(fg.om '97)

and obviously valued this role and the care they could offer such mothers.

The Benefits of a Continuous Relationship

Continuity was the basic feature of the relationship which facilitated, over time, the development of confidence and trust. According to the midwives this had important consequences for the care they were able to provide, most notably that they considered the women very differently once they 'knew' them. One midwife talked of only having a 'snapshot' of couples when caring for them in hospital, something akin to Davies 'fleeting encounters' (1995). This was compared to the more holistic 'knowing', as the midwife came to understand a mother's social situation and their personal characteristics and reactions. The midwives considered this enabled them to offer more appropriate care:

'I think because you are out in the community and you're in someone's house you're actually speaking to the woman and seeing things from her perspective and you see the outside factors as well – like her children, her relationship with her partner and those things that you never ever see in the hospital; you see the women as individuals.'

(i.pm062)

'And they really do tell you things. Very deep things. Very personal things. But it does make it easier to look after them because you can actually see why they're behaving that way or going through it.'

(i.pm23)

Establishing a relationship with women to the extent that they trusted the midwife enough to disclose intimate concerns was found to take time, as highlighted in a focus group interview with new caseload midwives:

X: *'I was really shocked the other day when a woman reached 34/40 pregnant before she was able to tell me that she had been sexually abused. It would never have come out in the conventional service. As it was I could be sensitive to every nuance.'*

Y: *'Yes. I had a woman who reached 36/40 then told me about her vaginosis.'* (fg.nm.'97)

Several midwives noted how 'knowing' a woman before labour influenced their reaction to her and their care provision when she was distressed in labour:

'Because I know them now and I know their personalities, when they go into labour, how they might cope with it because – you never know what somebody's going to be like in labour but because you know them you can – offer them support really because... Whereas when you go in and look after a complete stranger, sometimes you don't – you're not really meeting the real them, you're meeting someone who's in a lot of discomfort and you don't really get to know them at all. So I think in that respect

I'm definitely more in tune with the women that I look after and I certainly respect (the) women – because I know them and I'll do the best to help them make the choices they want – you know, to help them achieve what they've said to me that they're hoping from the birth.' (i.pm062)

The advantage derived from providing continuity of care was thought to extend beyond just the provision of more sympathetic, appropriate care to potentially having a positive effect on labour. A midwife who had experience with a caseload, then worked in a conventional service and moved back to a caseload noted:

'It's very easy to look after women in labour when you know them. That's one of the things I noticed (on return to conventional service), I found it very difficult looking after people in labour than I do women that I know. Because you've got to build up this relationship with them, got to know them, (and they've) got to like you. You've gone through all that by the time they go into labour. It's far easier.'

Researcher: 'Do you find they labour more easily?'

'Yes. They are far more relaxed. Totally relaxed. You discuss so much before they actually go into labour that when they're in labour it makes it far more easy and you can discuss things better, eg. foetal monitors. Its all been discussed and then they can see all your reasons why you would do it, why you wouldn't do it. They just come in and they do so much better. Even when they end up with a caesarean section or whatever they seem to do better afterwards – seem to recover better and psychologically they're better.' (i.pm23)

Care provision within the conventional service was seen by the caseload midwives to be limited, in terms of responsibility and actual care provision, by the lack of continuity:

'In the hospital setting if there is something that you're not sure about you pass the buck to either the doctor or whoever's around and often, because you are so busy in the hospital setting, you don't get the chance to follow through to see the outcome, to have it properly explained to you. You pass the buck. Full stop. You've done your responsibility. You've handed it over and you get on with something else; whereas with a caseload it doesn't stop. You have to follow it through. You have to make those decisions and you have to find out for yourself.' (i.pm062)

Several caseload midwives considered their colleagues practising in the conventional community situation did not understand 'real' continuity of care and the advantages it held for midwives:

'... and I used to get so frustrated about the whole thing and say - you just don't know what continuity is about.'

Researcher: 'And what is continuity about?'

'It's knowing these women and having a really good relationship with them so that you just don't have to be with – you have to be there, but not as someone telling them what to do when they're in labour. I mean, I can stand back in the room, Trudy, and

just let them get on with it and they'll just ask me what they want. You know, whereas when you don't know them you continue to say - well how about this then, what about that or have you thought about pain relief? Bit inappropriate time to be discussing these sort of things.'

(i.pm23)

Terminating the Relationship

However 'meaningful' the 'professional friend' relationship became, it was initiated for a distinctive purpose which was time limited. Other writers have noted the 'grief' mothers expressed when it ended (Wilkins 2000; Walsh 1999) and it was clear from this study that the midwives felt sad to 'say goodbye' when discharging some of 'their' mothers.

A few midwives acknowledged that some of the relationships had continued as genuine friendships maintained beyond the professional context. Other relationships were terminated more slowly, the formal discharge being followed up by the midwife occasionally popping in for an informal visit or a chat over the phone. Several mothers were reported as becoming pregnant again so they could receive care from the same midwives before the project was terminated; such '*re-offenders*' appeared to be warmly welcomed by 'their' midwives.

Perhaps the most obvious display of the nature of the relationships formed was observed at the annual caseload midwifery re-union party held in the hospital canteen. Organised by the midwives and mothers themselves, all women who had received care within the project were invited back for a tea-party with their children. The atmosphere was riotous. Many women attended and the greetings of joy and tears observed to be expressed by both midwife and mother appeared more akin to the reunion of long lost friends than a relatively short-term relationship formed for a professional purpose.

Issues Not Addressed

It is important to acknowledge that relationships do not always 'work out'. Personality clashes are inevitable in all social encounters and, as such, need to be allowed for in the delivery of a personal service. Mothers being offered caseload midwifery were given an information sheet about the service that included details of how to contact the practice administrator and manager in the event of a query or desire to change midwife. Although mothers who were particularly confident or who felt strongly about the situation might have availed themselves of this opportunity, and it was reported that a few did complain or change midwives, it is questionable if all mothers would feel so enabled. How far the caseload midwives felt able to acknowledge such problems and negotiate with their colleagues and mothers a change in primary carer was not determined.

Similarly, this study did not consider the degree to which caseload midwives facilitated mothers to have choice concerning their care. Clear intentions were stated in policy documents and clearly a degree of choice was offered, as reflected in the increasing number of home deliveries, the number that elected to have antenatal care other than at home and the number, although small, of women that refused caseload care. How that choice was offered, or the degree to which a caseload midwife 'managed' the choice was not a focus of this study.

Nevertheless, such issues did emerge from the arm of the evaluation that focused on women's responses to care; those who had caseload care were more positive about the individualised care and support they received than those who received conventional care (McCourt and Pearce 2000; McCourt *et al* 1998).

CONCLUSION

In both this and the preceding chapter, this analysis of caseload midwifery indicates a style of practice that demands and creates very different attitudes towards work, professional colleagues and mothers than those promoted by the conventional services. Midwifery knowledge and skills were developed as exposure to a variety of situations demanded adaptation and application, and further enhanced by the feedback and reflection facilitated when providing continuity of care.

The caseload midwives may have been initially motivated by frustration with their experiences of the convention service. However, their motivation was then stimulated by the positive professional environment they were able to develop within caseload practice. In part this was likely to be related to the initial excitement of being involved with a challenging project and the sense of cohesion that generated. Nevertheless, it was then sustained by particular features of caseload practice. Working with like-minded practitioners, the development of supportive colleague relationships, and the respect that they eventually won from other professionals all served to increase their job satisfaction and motivation. The very different relationship they were able to form with mothers on their caseload was identified as a further important source of satisfaction.

By terming this work '*real midwifery*,' the caseload midwives indicated a convergence between the ideology of midwifery as taught and that previously experienced in practice.

In this aspect, and perhaps others, the theory:practice gap could be bridged in a manner that has been found difficult in institutional practice.

Practising this '*real midwifery*' engaged the midwives in a more direct and individual way than in the conventional services as personal characteristics and circumstances influenced the strategies they adopted in 'making the job work for them'. Re-negotiation of the relationships they formed with colleagues and mothers involved issues of power, authority and control. Their ability to be flexible and responsive to the needs of the mothers they cared for as well as their personal needs demanded a re-orientation to their lives and the ways they perceived and constructed their time. Such issues of 'self', power and time, identified as fundamental to caseload practice, form the foci of the following three chapters in which this analysis of caseload midwifery is developed. The significance of these issues, and of continuity of carer as a basis for care provision, will be discussed in Part Five in relation to other models of care and the sustainability of the caseload midwifery model.

Chapter Ten

PERSON NOT PERSONA

THE INVOLVEMENT OF THE 'SELF' OF THE MIDWIFE

INTRODUCTION

As highlighted in the previous chapter, one of the striking features of caseload practice was the enormous sense of job satisfaction reported by the midwives. Positive features of clinical practice and colleague relationships, and the relationships the midwives were able to form with women on their caseload, were identified as the main reasons for this. Fundamental to the development of both was the issue of continuity, without which neither would have been able to flourish as strongly.

Analysis of schemes implemented to improve continuity of carer have highlighted the quality of the relationship caseload midwives were able to form with their women (Sandall 1997; Walsh 1999). However, little has been undertaken to unpack what it was about the relationship that was so significant, or to consider what the implications of this might be. The detail of this study permitted an analysis of these issues, from the perspective of the professional. Though not focusing on the mother's 'side' of the relationship, the analysis also highlighted issues of possible benefit for mothers. These perspectives are presented as the focus of this chapter.

In examining the nature of this relationship, it became apparent that the midwives were being engaged as individuals rather than members of an occupational category, and that they were gaining personally from the relationship formed. Caseload practice engaged and benefited the 'person', not just the 'persona' of the midwife.

Two main themes emerged from the analysis of this phenomenon, 'involvement of self' and 'reciprocity', with a sub-theme of 'investment' also identified. Consideration of these themes highlights the possible emotional costs and benefits of caseload practice, and offers a deeper understanding of the nature of the job satisfaction these midwives experienced when working with a caseload. It also raises a suggestion why, for some, this may be a more stable and beneficial service for midwives and mothers than the conventional service.

INVOLVEMENT OF 'SELF'

This theme was identified from discussions and interviews held with the caseload midwives. As previously noted, in carrying a caseload the midwives considered they became recognised and related to as individuals. However, it also appeared that the work engaged something intrinsic to their being. This required a movement from 'acting' the 'role' of midwife, to 'being' a midwife, a notion also identified by Öhlén in his concept analysis of the professional identity of nurses (Öhlén and Sengesten 1998). In a manner similar to the fusion of their use of time for work and social activities, so the nature of midwifery became part of their life, with the unique characteristics and skills they brought to their work being recognised and valued – both by their colleagues and their clients. 'The midwife, Mary' became 'Mary, the midwife'.

The midwives talked about '*actually being a person again, not just a cog in a wheel*', and highlighted the way women related to them as individuals, as people; coming out of uniform was considered important in facilitating this. The implication was that they had not been considered and valued as people when working in the hospital service, merely pairs of hands to get the work done, like caring robots. They also considered that they used many of their personal skills in their daily work that they had not found utilised in the hospital system. Experiences and knowledge gained in previous work environments now became recognised and valued by their clients and caseload colleagues.

No longer tied by the routines and immediate workload pressures that dominated hospital practice, caseload midwives reported being more creative in their practice, responding to the needs of their women in a more imaginative way than they had experienced working in the 'confines' of the hospital. They were able to practice the 'art' as well as the 'science' of midwifery in a manner that drew on their individual skills and strengths, not just their technical abilities. This feature was facilitated by their sense of 'ownership' of their caseload in accepting responsibility for care provided.

Discussing the satisfaction they had gained from their work, during 'exit' interviews the midwives described how they had been engaged by caseload practice:

*'... doing a job that matters. Making a difference by **your** decisions, not just carrying out care that someone else tells you.'* (her emphasis) (i.pm20.2)

'You can portray your life and your personality in your work.' (i.pm16.2)

'Your work is the only part of you that is your individuality; "this is what I've achieved. This is what I can do".' (i.pm08.2)

For them, the organisational features of caseload midwifery facilitated a realisation of themselves in their work, a situation they had clearly found impossible when working in the conventional services. This sense of self-actualisation will be addressed further when considering reciprocity.

Nevertheless, the greater involvement of 'self' held the potential for the midwives becoming so deeply involved in particular situations that their capacity to act in the best interests of the mother might be limited. Personalisation of the practitioner might result in a loss of professionalism; it might also endanger their own emotional stability.

Negotiating the 'Emotional Minefield'

The emotional costs to those involved in the caring professions have been recognised (James 1992; Bolton 1997; Hunter 2001). All forms of 'bodywork' (working directly on the bodies of others) involves negotiating the delicate balance between nakedness and touch, intimacy and distance; the potential link this holds with physical and emotional closeness has been stressed by Twigg (2000, 2001). Midwifery is perhaps the most intimate of bodywork occupations, being referred to by both Flint (1986) and Hunter (2001) as an 'emotional minefield'. Involved with the emotions of labour and miracle of birth, midwifery centres on sexuality, intimate personal 'dirty' work, and coping with pain and deep distress as well as hopes and fears. Hunter questioned how midwives deal with their own emotions, let alone those of the woman, her family, doctors, and colleagues (1999). She noted how this area, although clearly central to the work, has been much neglected in midwifery research, the majority of insights coming from disciplines such as nursing and other, apparently unrelated, research (Hunter 2001).

A seminal study that focused on the emotional responses of those who undertook 'people work' was undertaken on the airline industry, rather than a caring profession. The way in which airline workers handled the emotional aspect of their work was studied by Hochschild (1979, 1983), who used the term 'emotional labour' to define *'the management of feelings to create a publicly observable facial and bodily display'* (1983:7). Such controlling of personal feelings to present an acceptable image is frequently considered as 'professional' behaviour and Hochschild's ideas have been usefully applied to medical

settings. For example: in her analysis of the development of an enterprise culture within the NHS, Bolton (1997) suggested nurses combined a professional air of detachment with the display of a caring attitude to create an emotionally controlled atmosphere. This helped eliminate embarrassment at invasive procedure but enabled the patient to still feel human; the emotions of both carer and cared for being effectively 'managed'. However, drawing from theoretical rather than empirical evidence and in applying an etic perspective to the situation Bolton, like others, failed to consider the potential for reciprocity developing within what she termed the 'gift' of effective emotion management. Such potential was highlighted in this study and its significance is considered later in the chapter.

Hochschild (1979) noted that employers expected workers to suppress their personal feelings in order to manage the feelings of others. This was achieved through the development of 'surface' or conscious techniques such as the professional mask, and 'deep acting' where the initial use of self-will became internalised then used as an unconscious technique. Although lacking substantive evidence to support this claim, and focusing on a commercial as opposed to public service industry, Hochschild's concept of 'feeling rules' offers a useful insight into the management of emotion at work. Such 'rules' govern the acceptability of displays of emotion; developed with each given culture these are used by practitioners to match feeling and situation (Hochschild 1979, 1983).

In applying these ideas to the NHS using a gendered analysis, James (1989, 1992) considered 'emotional labour' as pre-eminently a female skill. This was heavily relied upon but not explicitly recognised or publicly valued in organisations focusing on technical rationality; a view strongly supported by Davies (1995) and Bolton (1997). In her study of hospice care, James considered this hard work, requiring the carer to give something personal of themselves, rather than a standard reaction. A similar situation was identified in Smith's study of student nurses; nurses were required to invest more of themselves in their job, yet the 'self' of the nurse was commonly denied by the 'feeling rules' and ethos of the unit (Smith 1991, 1992). The 'cost' of this to the carer is not defined but it clearly holds implications for their psychological wellbeing.

Such a concern was raised by Morse *et al* (1992) who questioned the limit to which caregivers can tolerate or find desirable such emotion-work when involved with patients who are suffering. The studies cited above all suggested that a degree of withdrawal and detachment might develop. For Hochschild (1979), the problems varied from the development of cynicism, due to awareness of the illusion that was created, or self-blame

from a sense of insincerity. Morse *et al* (1992) considered nurses developed a '*pseudo-engagement*' strategy that enabled them to remain detached and disembodied from constant contact with suffering; whilst Smith (1992) identified a '*caring trajectory*' movement within practitioner work, from an initial high level of focus on patients psychosocial needs to a focus on technical skills. Such task-focused orientation was considered as a coping strategy in a stressful and demanding job. These reactions were identified as responses to the constant demands of their work.

However similar strategies of 'distancing' have been promoted in nursing as a form of 'professionalism'. Menzies (1970) classic paper, although somewhat obscure methodologically, details how devices such as task orientation, depersonalisation, categorisation and denial of the significance of the individual were all developed within hospital organisations as defensive techniques designed to protect nurses. The psychoanalytical definition of the helper as 'one who established distance as a part of the professional relationship', promotes the classic warning for nurses of 'not to become too involved' (Benner 1984), although the efficacy of such protective distancing techniques was questioned by both authors.

With the institutionalisation of childbirth, midwifery is akin to a branch of nursing; the majority of practitioners initially trained as nurses and are likely to have absorbed the distancing techniques promoted as professionalism. Also, overt acknowledgement of the emotions surrounding birth tend to be submerged by the influence of science and technology, and sheer pressure of work; the speed with which families pass through the hospital system generally mitigates against close personal involvement. However, recognition of the importance of 'emotion-work' in childbirth is developing.

Giddens (1987) drew attention to the fact that, although religion has been devalued in modern society, recognition of some form of spirituality remains high. Moreover, technological interventions in birth are sited within social relations and often serve to generate further emotions, involving hopes, fears and difficult decisions to be made. Acknowledgement of a spiritual aspect to childbirth has, in the UK, remained largely the domain of lay carers, feminists and mothers rather than professionals (Hall 2000, 2001); nevertheless, the UKCC (1993) Rules of Practice required practitioners to meet the physical, emotional, **spiritual**, and educational needs of mothers (own emphasis). The emotional and spiritual needs of families need to be acknowledged and addressed, whatever the cost to the carer.

Recognition of this has occurred within a health service climate of increased consumer power. The expectation is for a quality service that is not just defined by techno-rational expertise; affective quality of care has become vital. This has been sought through initiatives such as 'primary nursing', in which the organisation of work becomes patient-centred rather than task-centred (Savage 1995; Smith 1992). The Weberian portrayal of the passionless bureaucracy in which the same standard of care is delivered to all, regardless of status or resource, has been replaced by a valuation now placed on 'emotional' organisations (Bolton 1997). Nevertheless, this ethnography indicated a hospital service organisation that was more closely aligned to Weber's theories of bureaucracy: roles were exercised by virtue of expertise and competence and a separation of the person from their role was encouraged; order was achieved through the rational character of rules and regulations which were impartially and universally exercised by 'impersonal' officials acting within the institutional structure. As Bolton (1997) rather cynically reflected, the new initiatives may be used more as tools to create the correct climate than to effect a major change of practice. However, the emotions of both client and practitioner have become legitimate discourse.

That women value the interpersonal skills of midwives; remembering the warmth or coldness of an individual and care provision long afterwards, is well recognised (Leap and Hunter 1993) and supported by research evidence (Kennedy 1995; Simkin 1991; Wilkins 2000). Childbirth involves a major life event for women yet is a daily event for midwives; their dilemma remains how to keep special that which is made routine.

The potential for over-identification leading to a loss of role boundaries and 'burnout' was a condition identified, particularly in relation to Team Midwifery schemes, in Sandall's comparative study of the effect of differing organisations of practice on midwives (1997, 1998, 1999). Sandall defined 'burnout' as a *'syndrome of emotional exhaustion and low personal accomplishment at work'* that could lead to a dehumanisation of clients, rejection of human contact and disillusionment with life in general (Sandall 1997:107). Midwives suffering from 'burnout', in feeling distant from women they cared for and disillusioned with their work, might respond in a way that generated the letter received by AIMS, stating:

'The midwives were all horrible. I have been on Prozac since I had my first baby three months ago and I know it is because of the way they treated me'.

(Robinson 2000:143)

Given the closer involvement entailed with caseload practice, resulting in a deeper knowledge of the women's hopes and desires, it may be argued that it is wiser for midwives to maintain the depersonalisation, even increase the professionalism, as an emotional protection against the event of a problem. As Menzies (1970) detailed, the variety of defence techniques adopted in nursing all involved minimisation of the nurse-client relationship, with denial of individuality, of feelings and of responsibility, whilst supporting detachment and objectivity with the development of a routinised task orientation. Nevertheless, these are precisely the opposite features to those embraced by caseload midwifery.

Menzies' work focused on the ways in which hospital systems developed mechanisms aimed at protecting nurses against emotionally distressing contact with patients. However, her analysis indicated that these did little to modify or reduce the anxiety experienced and may even have contributed towards its increase. An alternative strategy suggested by Benner (1984), was of involvement, not distancing, so practitioners were able to draw on their own coping resources and those offered by the patient, family and situation. Distancing techniques were considered to dimly protect from the pain of a situation, and also prevented the practitioner from taking advantage of the resources and possibilities that came through an engagement and participation in the patient's and families' meanings and ways of coping (Benner 1984:164). Morse *et al* (1992) in considering nurses' different responses to suffering made a similar point. Comparing 'clinical' therapeutic empathy with the 'natural' emotional empathy of nurses who deliberately became involved and engaged, the latter was seen to use more energy than with a routine professional response but they considered:

'Such relationships are described as rewarding for the caregiver, and the reciprocal nature of the exchange should reduce rather than increase the nurse's risk of burn out.' (Morse *et al* 1992:820)

For the caseload midwives, the organisational features of the model of practice enabled them to recognise and respond to each individual situation. Autonomy of practice and expectation of continuity gave them space and time to get to know the particular circumstances of each mother; recognising the individuality of each case they became special because they were different and they demanded different responses. Emotions were engaged, but were 'worked through' by midwife and mother, not denied behind a professional 'mask'.

Recounting her experience of caring for a mother after a previous stillbirth, one midwife noted:

'She had two others since then and she's as happy as anything – because I went through that traumatic time with her and it helped her to grieve and it helped her to accept the other two pregnancies much more easily. Because I knew (what she had gone through) we could talk about it much more easily.' (o.no.6.pm21.'97)

Such responses support Benner's notion of engagement being a more effective technique for dealing with these difficult areas of emotional labour. Rather than increasing the potential for emotional distress it is probable that, by facilitating such engagement with families and through the acknowledgement of 'self', caseload practice held the potential for offering a protective mechanism for midwives.

A contributing factor to this involvement, actuated by providing continuity of care, was the midwife's ability to engage with the developing situation; a phenomenon termed here as 'investment'.

INVESTMENT

'Investment' involves both a time orientation – a 'looking to the future', and the notion of self-gain – the investor having the expectation of some benefit from the outlay. The category arose in conversations with the midwives from comments such as:

*'During the booking visit you are **investing** time for the future.'*
(my emphasis) (i.pm 08.3)

It was an idea that was closely linked to the expectation of continuity and the autonomy the midwives experienced. Their work with an individual held a greater significance knowing that they would be following through a case and had the power to influence the situation. This contrasted with the frustration they reported experiencing when working in the hospital, when care and advice provided whilst on duty was countermanded by a colleague working the subsequent shift.

This concept was illustrated during participant observation of midwives' working practices. Caseload midwives demonstrated a clear future-orientation in their discussions with mothers; looking beyond the current and immediate-future issues to subsequent stages of the childbirth process, whilst building on past conversations. They reported being able

to provide information at the individual's pace, offering as little or as much as appeared appropriate at the time, yet ensuring mothers were prepared for the next stage of their pregnancy. The midwives considered that they found caring for mothers in labour much easier as they had '*done all the work before hand*'; not only were they confident the issues had been covered, but having been involved in this themselves they were aware of the mother's responses. Even if the delivery proved difficult, for example an emergency caesarean section was necessary, if the 'ground work' had been done properly, they reported the mother seemed able to cope without undue distress, a situation supported by psychological studies (Green *et al* 1988; Oakley and Richards 1990).

This 'looking to the future' orientation of the caseload midwives' approach contrasted with the present-orientation and 'immediacy' observed in the community midwives' practice. In these visits, both at home and in GP clinics, the midwives focused on the situation in hand, for example, the antenatal examination and issues the mother might raise. However, they were clearly reluctant to talk too precisely about future events, fielding questions and avoiding commitments by using the 'verbal asepsis' and 'routine patter' techniques described by Kirkham (1989). When queried, they reported that, as they would not necessarily be involved in the care provision at that stage they felt unable to speak for their colleagues who would be responsible. This was particularly noticeable in discussions concerning mode of delivery. In one instance a woman, at 36 weeks' gestation, attended the GP surgery for an antenatal check by the 'regular' midwife, whom, it transpired, she had never seen during this pregnancy. The midwife asked if 'DOMINO' or home delivery had been discussed by her colleagues and on receiving a negative response did not pursue the matter further. The mother would have been a suitable candidate for either option, had she so desired. The choice was never offered.

The number of observations undertaken with the community midwives was small, thus the findings are suggestive rather than conclusive. However, for the caseload practitioner, providing continuity and having responsibility were seen to be categorical in their being able to 'invest in' and 'build on' care provision for the future event of childbirth and subsequent motherhood. The disappointment the caseload midwives reported if they had not been present at the delivery reflected the personal satisfaction this investment could give them. Comments made at such times were particularly illuminating:

'You are with them for all that time and then miss out at the end – you've missed the bloody party! That's what I feel.' (cc. pm 18)

'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.'

(fg.nm.pm34 '97)

Continuity for the midwives enabled the investment they put into their work to be worthwhile, in a way that made sense to them individually. The 'interest' on their investment was reaped at delivery; not to be there proved a source of frustration and annoyance:

'When I phone (names partner) on a Monday after being off for the weekend and she says X delivered, I feel, umm (grimaces and makes a face to indicate emotion) very down, fed up, upset. It's us that minds. We like to think they want us and are upset if we're not there, but it isn't true. Now it's us that wants to be there, that's why you put yourself on call so much, you don't want to miss the end – it's the icing on the cake.'

(cc.pm.11)

Caseload practice entailed the midwives becoming more deeply involved with their work than conventional midwifery practice permitted. Such form of engagement could go beyond an 'investment' of their professional skills to ensure a meaningful outcome. It also encompassed something of their individuality that they gave and something that they received in return, some benefit they appeared to gain from working in this way. A sense of reciprocity was identified as a major theme in this analysis of the involvement of 'self', reflecting the different nature of the relationships midwives could form with mothers in caseload midwifery.

RECIPROCITY

Although clearly giving of themselves in a way not demanded by the conventional service, a strong sense emerged that caseload midwives were also benefiting from working this way. This related to something that was not seen when observing the community midwives or working with the hospital midwives, where work was seen and experienced as essentially a one-way transaction; the midwife gave advice or care to the mother. Response from mothers, a warm 'thank you' or token gift of appreciation, appeared superficial compared to the caseload midwives' experiences.

Health service professionals are expected to undertake their work with no expectation of personal gain, apart from a salary. Hence it seemed important to identify what, if anything, the midwives were receiving, perhaps as an acknowledgement for care provided. Sensitive

exploration of this area revealed some thoughtful gifts had been received, and it was clear that the midwives valued the thought behind the gift, expressed both in the choice of item and on the cards, rather than any material worth. These were treasured, stored in albums and shoeboxes that swiftly became full. Nevertheless, the sense remained that there was something more than the physical gift involved, a sense strongly affirmed by observation of the annual reunion 'birthday party' where the joy expressed by mother and midwife appeared genuinely mutual.

When asked by questionnaire what they gained from caseload practice, the midwives identified only tangible benefits: increased confidence, midwifery development, greater understanding of the context in which they were working, positive relationships (Table 15). Such issues contributed towards their development but did not indicate the intrinsic gain that had been identified.

Table 15 Personal and professional benefits from carrying a caseload (n=30/35)

<ul style="list-style-type: none"> • Increased Confidence (14/30 used this term) in: <ul style="list-style-type: none"> All aspects of practice Own judgement, ability and skills Professional relationships Giving presentations General, particularly assertiveness • Midwifery Development <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Dynamics of an NHS Trust Personal practice (through reflection and peer review) Women's needs and family lifestyles • Relationships: <ul style="list-style-type: none"> Inter-disciplinary and with colleagues • Completing Studies (3) • 1 gave no response

Source Questionnaire 1997

The strength of the ethnographic approach is that it enabled the theme of reciprocity to be identified from 'the whole' rather than from particular elements of data. The 'sense' of something significant emerged from 'being with' the midwives as opposed to anything that was articulated during interviews or focused observation. Subtle indications were given in

the quality of relationships observed, tone of voice, body language used, but little articulated evidence was found to exemplify the 'sense'. The comment made:

*'If I've got a quiet day I'll enjoy their company and **their input to me** rather than just me giving to them'* (my emphasis) (i.p.13)

was indicative of the potential for something reciprocal in the relationship but it proved difficult to demonstrate substantive data determining the exact nature of this reciprocity. Nevertheless, particularly during informal conversations with the caseload midwives, it appeared as an important component of the professional-as-friend relationship discussed earlier. Reference to the literature was made after the phenomenon had been identified in the analysis. This proved helpful in confirming that a subjective interpretation had not been imposed on the data but that a characteristic previously noted elsewhere had been recognised. It also provided insights as to the possible significance of such reciprocity.

Reciprocity in the Literature

The concept of reciprocity features in a wide range of literature relating to practitioner–client relationships, both theoretical and substantive. In his classic sociology of the professions Parsons (1951) depicted doctor–patient relations as a 'reciprocal set of roles', although these were determined by obligation, confirming a hierarchical social structure rather than creating a balance of power in the relationship. Such a balance was inherent in Korn's (1964) model that included reciprocity as a characteristic of the 'expert as co-learner'; this stressed a transactional sharing of learning and mutuality between expert and client. This notion was implicit in Schön's (1983) ideas for a new form of professionalism based on a 'reflective contract' between practitioner and client; although, as with Parsonian theory, this was a structural feature premised on obligation.

The concept of reciprocity was also implied in Benner's (1984) original explication of the 'expert' nurse, in her consideration of positive powers within the nurse–patient relationship and the protective mechanisms that could be activated for nurses. However, criticised for detailing the nature of expertise but not the ways this could be achieved, the ideas which helped inform this study were not taken forward in the subsequent development of her initial work. Focusing a phenomenology of expertise on intensive care work, and the ways in which nursing expertise can be understood, taught and promoted (Benner *et al* 1996), the reciprocal nature of client–nurse relationships that might further inform an understanding of caseload midwifery was absent.

In midwifery, the theme of reciprocity emerged in studies of models of care that involved continuity of carer but was not present in McCrea's (1993) study of the midwife–client relationship where continuity was absent. Sandall's (1998, 1997) comparative study of organisations of midwifery noted how practitioners carrying a caseload, as opposed to team practice, were able to establish meaningful relationships with their women, and that *'they gained immense satisfaction from working this way and received much support from the women'* (1997:109). The 'support' was not defined. In a study of a pilot caseload scheme, Walsh (1999:173) defined the relationship women had with their midwives as being *'informal, personal, and reciprocal'*, defined as *'mutual sharing'*. Again, the concept was identified but not developed further.

The idea of reciprocity was more clearly defined in studies from New Zealand where continuity of carer schemes have become firmly established, with a strong element of a midwifery partnership with women. In rejecting the conventional medicalised model of care, in the early 1990's a new model of midwifery practice evolved from the conscious collaboration of women's groups and midwives in New Zealand. The centrality of partnership was adopted as both an ethical stance and a standard for practice. Guilliland and Pairman (1994), in their theoretical outline of this midwifery partnership, suggested it is based on a *'relationship of sharing'*, highlighting how the empowerment aspect can also be reciprocal:

'...being part of a process where the woman takes hold of her personal power and directs her own experience is a source of affirmation for the midwife.'
(my emphasis) (Guilliland and Pairman 1994:8).

The centrality of 'reciprocal trust' in the relationship was noted in Lauchland's (1996) reflective commentary on the Guilliland and Pairman model, and further developed in Pairman's later analysis of this partnership. Although based on a very small and specific sample (six dyads from independent practice) these relationships were identified as including a *'reciprocal exchange of intimacy and love'* and *'mutual benevolence as reciprocal goodwill'* (Pairman 1999, 2000:219, 223). However, the consideration that reciprocity was fundamental as well as central to the relationship was made by Fleming (1998). In research undertaken with both New Zealand and Scottish maternity care systems, her analysis of midwifery as 'a model of interdependence', identified reciprocity as *'the basic social process, or core category, which was present throughout'*. This supported the more transitory, yet major categories of *'attending, presencing (sic), supplementing, complementing, reflection and reflexivity'* (Fleming 1998:140). For

Fleming, reciprocity '*seemed to be the essence of all successful midwife–client relationships*' (my emphasis) (Fleming 1998:142). However, she failed to 'unpack' the concept, merely confining it to 'an exchange of ideas' and '*bringing together hopes and aspirations to create the reality*' (Fleming 1998:142).

Ideas concerning reciprocity were most clearly articulated in Pairman's 1999 paper where a sense of the real significance of the concept began to emerge:

'Intrinsic to this equal relationship is the notion of reciprocity. By this I mean a two-way sharing in which both the midwife and the women are active participants in creating the relationship and both are affected by it.'

'Partnership is about recognising and accepting the other, communicating, striving for mutual understanding, redressing power imbalance and creating space for both partners to grow in their own way and achieve their own goals.'

(Pairman 1999:9)

Although not developed, the inference is of some personal benefit for the midwives, as well as mothers; something that they, as individuals, were able to achieve from the relationship.

The midwifery literature clearly supports the concept of reciprocity forming one of the important features of the midwife–mother relationship that may develop with continuity of carer schemes. Nevertheless, determining the nature of this was recognised as being difficult (Fleming 1998), and the significance of it has not been explored.

An understanding of the possible implications of reciprocity may be usefully informed from disciplines such as anthropology and social psychology. Ideas concerning reciprocity and gift relations, and self-actualisation and work motivation, are relevant to caseload and conventional practice, and raise issues relating to sustainability and the importance of caseload care in post-modern society.

Reciprocity and Social Relations – changes in a service industry

Reciprocity: *Reciprocal condition, mutual action, principle or practice of give-and-take.* Concise Oxford Dictionary 1982

Reciprocity: *The return of a gift or presentation.* Macmillan Dictionary of Anthropology 1986

Reciprocity formed one of the key concepts in studies of pre-industrial societies, with anthropologists from Malinowski onwards being fascinated by the importance of the exchange of gifts and the relationships this established. Central to such analyses has been

Mauss's (1970 [1925]) classic exposition on the gift relationship in which he defined three central tenets: the obligations to give, to receive and to repay. The acceptance of an object places the receiver under an obligation to make a return at some future time; the giving of something sets up the expectation of return. Thus social relationships are established, confirmed and maintained in a continuing cycle of exchanges. Reciprocity in Mauss's terms entailed the moral obligation to make a return to the donor.

The concept of reciprocity has subsequently informed many aspects of anthropology. Nevertheless, as MacCormack (1976) warned, it has been so fundamental to the discipline that it has become overworked and confusion over interpretation developed. Most commonly the argument centres on whether reciprocity dictates a rule of behaviour or reflects that behaviour. It is important to clarify that, in this analysis of caseload midwifery, the term reciprocity is used in the latter sense, to aid an understanding of what is occurring in this different form of midwife–mother relationship. There is no implication that the reciprocity identified involved a mandatory response on either part; the term is used here as a reflection of apparent behaviour.

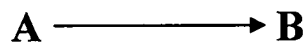
Polanyi's (1968) and Sahlins' (1972) economic analyses both offer useful insights to considerations of the implications of midwifery having moved from a private occupation to a service industry. Polanyi drew on Malinowski's descriptions of the Trobrian Islanders' *kula* exchange and Mauss's ideas to focus on the redistribution of labour and goods – rather than taking a Marxist focus on mode of production. Arguing a substantivist position, he divided economies into three types according to the dominant mode of distribution: reciprocity, redistribution, and market exchange; the distinctions were seen to reflect major differences in the social structure of each society (Polanyi 1968). The importance of reciprocity was considered to diminish in direct relation to the development and dominance of the market economy; money replaced reciprocity, negating any moral obligation to make a further return. This form of contractual relationship was considered the norm in a truly commodified industry, where labour and all material objects were given a monetary value, and the use of the coin replaced the obligations that would have been established had money not been used. With the addition of a third party, this forms the model of exchange in the commodified health service industry, where 'consumers' and service providers negotiate the contractual arrangements and practitioners provide the service.

Polanyi's idea of money completely depersonalising exchange relationships has been questioned (Hart 1986), with recognition of the centrality of social relations to all forms of

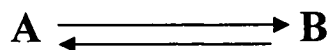
exchange remaining persistent. Nevertheless, such a change was noticeable with community reactions to government payment of Traditional Birth Attendants following training (personal reports); the level of support previously given diminished considerably. This suggests that relationships established when the local 'handywoman' birth attendant was paid in kind rather than cash by the 'employing' family, would have been radically altered when the midwife became salaried by the Local Health Authority, and further undermined when she became the employee of the local NHS maternity hospital. The direction of any sense of obligation generated by the economic exchange would have changed from mother and midwife to institution.

An alternative to Polanyi's substantivist analysis was offered by Sahlins (1972) who, in focusing on the relationship established by economic exchanges, developed a typology of reciprocity that he correlated along a continuum of social distance:

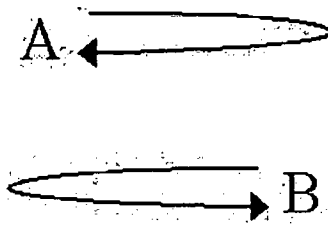
a) Generalised Reciprocity where the emphasis is on A giving to B with little expectation of direct return. Where social distance is close and long term, relationships are between family and friends; where distant, notions of charity and the 'free gift' are involved. On a more general level this equates with the paternalistic emphasis of the welfare state and the NHS principle of 'from all according to their ability, to all according to their need'.



b) Balanced Reciprocity the emphasis is on direct exchange. A gives to B and B returns to A. Social distance is midpoint – an exchange between structured equals who trade or exchange goods or services; or gifts between social equals. This equates with the position of Traditional Birth Attendants and pre-NHS midwives and, I will argue, relates to caseload midwifery.



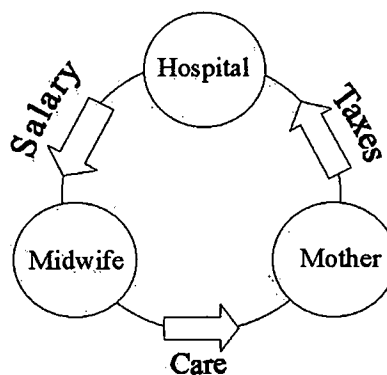
c) Negative Reciprocity the emphasis is on obtaining 'something for nothing', to maximise personal advantage; eg. barter. Reciprocity in this situation is contingent on the defence of self-interest; social relationships are distant, eg. unknown or enemy.



The important feature of reciprocity is the power differential that is created when there is an imbalance; the giver is perceived to have greater power, a situation resonant of the professional–client relationship. Although ‘private’ consultations involve a direct exchange of expertise for money, suggesting the professional–client relationship is theoretically equal, this is rarely the situation given the centrality of knowledge to power (Foucault 1980), an issue discussed further in Chapter Eleven.

An NHS maternity service has elements of both Polanyi’s market exchange and Sahlin’s free gift (*see* Figure 4). Relationships established through the exchange mechanism are relatively depersonalised, and a sense of direct reciprocity is negated.

Figure 4 Economic exchange involved in the NHS health care system



Movement around this circle is almost completely one way. For the mother the service received is a ‘free gift’ at the point of contact; unless wealthy or prepared to fight, she has minimal choice or influence over the situation and no ‘bargaining power’. For the midwife, reciprocity from the mother is replaced by salary from the institution.

There are certain obligations involved in this situation, but they are not directly reciprocal. The midwife is obliged to provide the best care possible (NMC Code of Professional Conduct 2002; UKCC Rules and Code of Practice 1998) but her obligation lies to her employer and professional body. The degree to which she involves her intrinsic self or not, is within her choice and control. On the mother’s part there is no obligation to respond to

the midwife's attention, other than in a manner in which the norms of social behaviour are observed. Her obligation is to pay indirectly for the midwife's service via taxes and National Insurance contributions.

In the maternity services this situation has resulted from the movement of childbirth from private to public domain, as detailed in Chapter Two. Reflecting Marx's theory of social relations changing with the mode of production, in this instance the development of a service industry, it has resulted in profound changes in the working relationships in maternity care. In his paper analysing the effects of the free-market enterprise on the health service, Mason (1995) suggested such relationships have become progressively 'dehumanised' by the demands of rational economics. This movement is in line with Giddens' theories on post-modernity and notions of '*emptying of time*' and '*dis-embedded institutions*', where traditional social relations have been broken by the dynamic forces of modernity (Giddens 1990). The cohesion of community ties has been replaced by impersonal contractual arrangements in a *gemeinschaft:gesellschaft* (Tonnie's 1887, trans.1955) distinction. Such change holds important negative implications for midwife and mother.

In clinical practice, the contractual arrangements result in an increasing expectation for health service employees to conform to strictly defined service 'competencies' or face redundancy (Mason 1995). Noting how '*the supremacy of commercial values replaces those of trust and co-operation*' (1995:10) Mason detailed how attention to economic efficiency and budgetary control has caused professional practice to be determined, and restricted, by defined standards of measurable 'competencies'. These are imposed on practitioners who are then forced to demonstrate competitive performance. For midwives, the loss of autonomy and sense of fulfilling a 'servant' type of role with its concomitant control of feelings could, in Mason's view only lead to situations of chronic stress. This theory was supported in Sandall's (1997) comparative study of midwifery practices which identified lack of control as being key to the negative effects of stress.

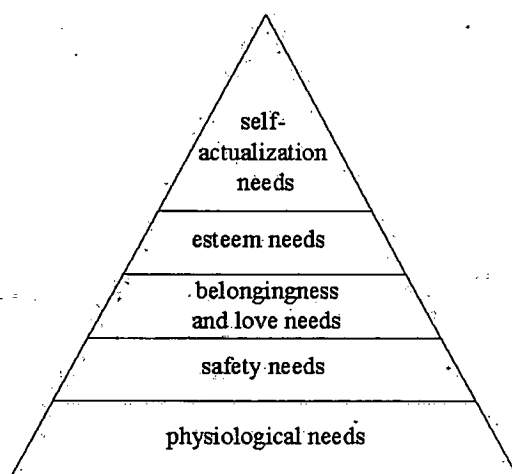
Moreover, a purely economic return for labour may not suffice, for as Mauss noted:

'The producer who carries on exchange feels ... that he is exchanging more than a product of hours of working time, but that he is giving something of himself – his time, his life.'
(1970:77)

This is a notion that clearly resonates with the earlier discussion concerning the midwives' involvement of self.

Consideration of Maslow's (1970 [1954]) hierarchy of needs develops Mauss' view by highlighting that an individual has more 'needs' than may be met by a purely monetary return for labour, *see* Figure 5.

Figure 5 Maslow's Hierarchy of needs



Adapted from Maslow 1970

This idea was supported in Herzberg *et al*'s study of motivation at work (1967). In addressing the question 'what do people want from their jobs?', the researchers identified the need for fulfilment of both 'hygienic factors' (that promoted a positive psychological work environment) and 'intrinsic satisfiers' (that enable an individual to achieve their aspirations). A sense of personal growth and of self-actualisation was identified as being key features contributing to an individual's positive feelings about their work. For many, something intrinsic to their beliefs and being needed to be met in their work. Although limited by number and focus (200 middle-management men), this weakness is acknowledged by the authors and the findings considered against a wider frame of reference. Clearly work situations and the desires of individuals differ widely. Nevertheless, the work does offer insight into the possible implications of the effect of different organisations of practice on midwives.

As discussed earlier in this chapter, caseload midwives were able to achieve a sense of self-actualisation that they had not found in the conventional service. This was exemplified in the movement from 'role' of midwife to 'being' a midwife and was probably an

important constituent of the enormous job satisfaction they expressed. Herzberg *et al* suggested that not fulfilling this need could result in a sense of alienation (Marx 1970) and 'anomie' or disconnection and associated loss of meaning about their work (Herzberg *et al* 1967; Durkheim 1951). Marxist notions of alienation hold strong resonance with conventional maternity services – involving a separation of worker from the product of their labour, fragmentation of the work process so it becomes task oriented and eventually meaningless, dominated by market forces rather than relationships. That midwives working in conventional forms of practice may be experiencing a sense of alienation and anomie, is supported by the work of Robinson (1983, 1989, 1990) amongst others. It might also explain the concern raised by Jean Robinson of AIMS (Robinson 2000:143) who, following receipt of a number of complaints from mothers, questioned '*Why are midwives turning nasty?*'. The relationship, once the fulcrum of a midwife's work, now holds minimal significance to midwives working in conventional services.

In the commodified NHS hospital service, the competing pressures of workload and limited time could result in the midwives' 'satisfiers' (Herzberg *et al* 1967) becoming focused on the task rather than the reason for the task. Thus a normal 'safe delivery' becomes the aim and intention, and achieving this proves a strong source of satisfaction for midwives (Hunter 1999). However, the purpose behind the delivery, the development of a family with the concomitant variety of hopes and expectations of the parents, becomes almost irrelevant. Tight time limitations result in the relationship with mothers being extremely intense, focused tightly on the issue in hand. Practitioners are encouraged to become skill orientated, gaining both reputation and pride in undertaking advanced skills and demonstrating their knowledge and use of technology; peers become the source of approbation and approval (Sandall 1999). This potential danger is increased with the movement towards competency based skills (UKCC 1999) and describes the ultimate development of 'midwifery' in Davies-Floyd's (1992, 1999) technocratic model of care (*see* Table 1, Chapter Two).

In this scenario all notions of direct reciprocity are negated, as befits the 'free gift' of Sahlin's generalised reciprocity; replaced by wages and taxes in Polanyi's market economy. However, the maxim 'there is no such thing as a free gift', in extolling caution, acknowledges expectations that may be hidden within the 'gift exchange' or service rendered.

The Myth of the Free Gift – Implications for a Service Industry

Sahlin's consideration of generalised reciprocity and the notion of the 'free gift' indicated that an exchange could occur where no expectations were set up; the giver sought no recompense and the receiver was placed under no obligations. The midwife gave her service and the mother received it. Subsequent work suggests the situation to be more complex. Due to the importance of the social relationships involved, a need for 'repayment' in some form may be established on both sides of the exchange.

The classic study of altruism in modern society, undertaken by Titmus (1970), belied the notion of a 'free gift'. In considering the place of medical care as a consumptive good in the private economic market, Titmus focused on a comparative study of blood donation in different countries. The UK, with its reliance on a system of voluntary donation, provided the setting for individuals to behave completely altruistically, with no potential for feedback or gain; the opportunity was presented to make a moral choice to give in a non-monetary form, to strangers. Nevertheless, Titmus found the donors' motivation was not completely altruistic; elements of an obligation, or seeking approval were identified. These he defined as provided the donors with a sense of 'inclusion in society'. A 'payback', however subtle, was sought. The implication of this work is the suggestion that, in 'giving' their services to mothers, midwives might also, even subconsciously, seek some form of 'payback' from the exchange. The most likely form of this would be the self-actualisation described by Maslow (1970) and Herzberg (1967). Denial or lack of opportunity for this may contribute towards a sense of frustration, increased stress, and eventually even 'burnout'.

The second consideration relates to the position of the recipient, the mother. Mauss's argument was that power lay with the giver and that in receiving the recipient was placed in a position of subservience. This notion is supported in ideas about charity work and the position of disabled people. In her forward to the 1970 edition of Mauss's *The Gift*, Douglas considered the role of charity in gift giving, acknowledging this was often considered a burden by the recipient. Although the donation may be welcomed, Douglas noted '*the recipient does not like the giver however cheerful he may be*'. A similar response has been highlighted in work undertaken with disabled people who strongly resist the sense of obligation and indebtedness inherent when in receipt of help (Perring 1999). As Mauss (1970) suggested, the unreciprocated gift still makes the person who has accepted it inferior, '*minister*'; charity may be wounding for him who accepts it.

The possibility of psychologically harmful effects arising from non-reciprocal 'gift' giving was the focus of Williams (1995) study of American parents whose children were receiving treatment for cancer. Arguing that receipt of aid or support creates an emotional cost for the recipient and alters their perceived status as an independent member of a social group, Williams used Sahlins' (1972) model of reciprocity to analyse parent's responses to the receipt of charitable financial assistance to support the care of their child. In such crisis situation she found the existing relationships of generalised and balanced reciprocity to be altered. Parents were aware and generally uncomfortable on receipt of the charity, but that the desire to reciprocate in some way was surpassed by the pressing needs of their child; this created a sense of impotency. A form of reciprocity was achieved when parents were able to offer assistance and support to others in similar situations, a phenomenon Williams termed 'stepwise reciprocity'. Williams suggested the ability to give back to others enabled the parents to regain a sense of control, helped diminish their sense of dependency, and promoted better psychological outcomes (Williams 1995).

It is possible that being in receipt of care yet unable to reciprocate in what the individual considers an appropriate manner, could have negative psychological consequences and contribute towards the sense of loss of control that mothers receiving conventional NHS maternity care have complained about.

The Significance of Reciprocity in Midwifery

Drawing on the ideas of Mauss, Polanyi and Sahlins, reciprocity may be seen as a fundamental characteristic of economic and social exchange relationships, of which midwifery, as a service industry and form of 'people work', is one. An imbalance in reciprocity will create a power differential and can result in negative psychological consequences for both parties.

The works of Herzberg *et al*, Titmus, Williams and Perring support the argument that caseload midwifery care holds the potential for psychological benefits for both parents and midwife. This is achieved through the development of a reciprocal relationship that the prolonged contact facilitates. Parents have the opportunity to address any sense of indebtedness they may feel towards the care provider, the midwife, enhancing their sense of control. Perhaps more significantly, midwives benefit from the reciprocal relationship by its contribution towards high levels of job satisfaction and less stress, thus reducing the potential for 'burnout'.

This argument is supported in social psychology by the theories of social exchange outlined by Buunk *et al* (1993). Relationships are in general considered more satisfying and stable when reciprocity is perceived, and when the rewards for each partner are perceived to be more or less equal (LaGaipa 1977, quoted by Buunk *et al* 1993). Their studies in a Dutch psychiatric hospital and national railway company highlighted that for some individuals the perception of reciprocity played a key role in their wellbeing; high levels of reciprocity promoted a sense of wellbeing and the perception of an imbalance caused strain.

This factor has not been considered in practitioner studies relating to stress and 'burnout', which tend to focus on the causes of, and coping mechanisms for, the management of stress (Dionne-Proulx *et al* 1993; Carlisle *et al* 1994; Wheeler and Riding 1994). For example, Mackin and Sinclair's (1998) study on sources of stress and stress relieving methods utilised by labour ward midwives noted the importance of support, but failed to consider any input from the mothers being cared for. This omission was also made in Bakker's *et al* (1996) study of 'burnout' among Dutch midwives, which identified supervising births in the client's home instead of a hospital maternity ward as reducing the risk of 'burnout' for community midwives. Personal resources such as support and coping style were considered to play an important role in this, but the potential for the development of a reciprocal relationship with the mother was ignored as a factor.

The second benefit for the midwives was sense of the fulfilment they achieved. The importance of work related fulfilment in the prevention of 'burnout' was raised by Boyle *et al* (1991) quoting two noted researchers on 'burnout':

'Even when people have stressful jobs that do not pay enough, if their work is meaningful to them, they will not burn out.'

(Pines and Aronson 1988; in Boyle 1991:857).

Sandall's (1997) study highlighted the importance of midwives being able to establish a meaningful relationship with women as a factor of reduced 'burnout'. It was identified as a major contribution to midwives' job satisfaction by Brodie (1996) in her study of Australian midwives' transition into team practice and Hundley's (1995) RCT of a midwife managed delivery unit. However, the nature of this meaningful work or relationship as noted in these studies is not defined.

Analyses from this study suggests that on the social level, the midwives valued the reciprocal relationships established, experiencing enjoyment in the communication and receiving acknowledgement of their personal interests. They valued when their individuality was considered; they talked of mothers who delayed phoning them because they were aware of some activity in the midwife's personal life, or 'waited' to go into labour until the midwife returned from a weekend off or from holiday.

Nevertheless, the midwives also recognised the dangers inherent in the development of dependency relationships (Purtilo 1993) and, in working with them, little sense was gained of individuals seeking to fulfil a personal psychological 'need to be needed' as suggested by Campbell (1984) in his analysis of professional care. The degree to which practitioners engaged their intrinsic selves was individual but boundaries were clearly drawn. One midwife who left caseload practice partly because of a problem experienced with defining boundaries, noted they had '*got it wrong*' and that it was easier to leave than change, although they wanted to continue working with a caseload.

On a deeper level, the midwives appeared to gain some sense of approbation of their work and being, of why they are a midwife. This idea is reflected in Pask's philosophical study of nurses' valuation of their work, where she suggested that '*the experience of making a difference to their patients*' proved a '*source of sustenance for nurses who invest something of themselves in their nursing*' (my emphasis) (Pask 2001:1).

Pask considered it was the nurses' recognition of their ability to make a positive difference to their patients that contributed to their personal professional identity, providing 'feedback' as a source of validation. High levels of satisfaction were achieved when a match between the nurse's personal goals, morality and view of how things should be and the reality were achieved.

'In making a positive difference to their patients, the self of the nurse appears to achieve that which she sees to be valuable, ... (this) affirms her own existence and results in feelings of satisfaction and fulfilment.' (Pask 2001:19)

In caseload practice, midwives clearly felt fulfilled and satisfied. In defining it as '*real midwifery*', they were affirming what they believed midwifery to be, and in being able to practice it in a way that made sense to them, they were able to achieve a sense of self actualisation (Maslow 1970; Herzberg *et al* 1967).

They worked hard and, along with conventional models, experienced the immediate stresses of clinical care. Nevertheless, where high levels of reciprocity were achieved, the potential for reducing the levels of stress that contribute to 'burnout', might apply. In contrast, in the market-orientated, institutionalised service of hospital midwifery practice, commodification contributes towards alienation, task orientation, reduced autonomy and flexibility – which are known to increase stress and 'burnout'.

Caseload midwifery appears to reintroduce the social relations formed by the gift of midwifery service, with the potential for positive psychological benefits for both mother and midwife. In anthropological terms the 'obligations' could be met, resulting in issues of balance and of stability. Delivered within the context of a service industry, this forms the 're-embedding' of face work commitment (Giddens 1990).

CONCLUSION

The analysis presented in this chapter highlights both the potential advantages as well as disadvantages that may be inherent in the deeper involvement of the 'self' of the midwife. No longer acting as the 'caring robots' of conventional service, caseload midwives valued the opportunity to express themselves through their work. Such 'self-actualisation' was facilitated by the organisational features of autonomy, responsibility and continuity. Continuity also enabled care provision to become an investment, the 'interest' of which was reaped at birth. Missing the birth then, held as much if not more significance for the midwife than the mother – who they recognised as being contented with good care provision by someone they had previously met. The midwives likened this disappointment to 'studying for exams and missing the results'.

This chapter has also suggested a theory of reciprocity providing important psychological benefits to both mother and midwife, and creating a balance in their relationship that counteracts the power differential inherent within conventional professional relationships.

Anthropological studies have indicated the importance of reciprocal social relationships in pre-industrial societies and how such relationships then alter with changes in the mode of production. It is suggested that such changes were an inherent part of the 'professionalisation' of midwifery, the 1902 and 1936 Acts generating and promoting a separation in the mother–midwife relationship. This was further split by the development

of the NHS and free medical care, the promotion of hospital birthing, and the subsequent medicalisation of childbirth, which was discussed in Chapter Two. Caseload midwifery addressed the ensuing dissatisfaction of both mother and midwife and appears to have re-established the potential for reciprocal relationships between the two. The positive psychological benefits this may hold for both parties, and particularly the possibility of offering a protective mechanism against undue stress and 'burnout' for midwives has been posited.

It has been argued that such personalisation of the practitioner does not necessarily involve a loss of professionalism but may radically alter it. The manner in which this may occur in caseload practice, redefining the nature of professionalism, is the focus of the next chapter.

Chapter Eleven

POWER AND PROFESSIONALISM IN CASELOAD MIDWIFERY RE-DEFINING THE PARAMETERS

INTRODUCTION

Consideration of the reciprocal nature of the midwife–mother relationship that could be established in caseload practice, reflects the centrality of power in such situations. Recommendations made in both the Winterton (HoC 1992) report and *Changing Childbirth* (DoH 1993) involved giving power back to women. The implementation of caseload midwifery practice was seen as one way this might be achieved, in addition to improving the position of midwives. However, if the intention was for women to have a greater degree of choice and control over their care, the potential existed for the changes to be a licence for midwives to increase their power base. It was possible that power would effectively shift between the professionals rather than devolve to childbearing women.

This chapter focuses on the status of the caseload midwives, considering aspects of power particularly in relation to the themes of ‘autonomy’ and ‘knowledge’ that emerged from the data. As these themes have been considered to form the fundamental basis of professionalisation (Friedson 1977) the implications of this for the occupation of midwifery as well as the individual midwife will be discussed.

THE CHANGING LOCUS OF POWER

As outlined in Chapter Two, the 20th Century proved a period of diminishing power for English midwives. Although midwives were traditionally considered as powerful people (Donnison 1977), this was generally considered to be enabling rather than controlling in nature. Such ‘power’ became contained by the 1902 Act, introduced to protect a clientele rather than a profession, and the advent of various mechanism of control. Developments in technology and knowledge, the expanding sub-specialisations of medicine, institutionalisation of childbirth and changes in their employment relationship all contributed towards disempowering midwives.

The manner in which this occurred may be understood by reference to theories of 'power' that focused on the development of knowledge (Parsons 1949; Foucault 1980), of professional groups (Parsons 1949; Freidson 1988; Johnson 1989), and of institutions (Weber 1978 ; Foucault 1977) as mechanisms for exerting and controlling power. However, all such analyses omitted the implications of gender that, fundamental to all power relationships, influenced the position of both mothers and midwives. That midwives were not alone in their loss of power, was highlighted by Arney (1982) who suggested such mechanisms were successfully utilised by obstetricians, first as technologies of domination and control then as technologies of monitoring and surveillance.

In medicalised childbirth, mothers' submission to, what Arney termed, a '*panoptic regime of control*' (1982:230) (*see below*) emphasises the link between the position of mothers and midwives in this disempowerment. Yet it is a 'link' that separates them, forged by mothers' 'allowance' and midwives' 'collusion' in facilitating the domination of a medical model of childbirth (Arney 1982). The re-emergence of a powerful midwifery profession in New Zealand appeared to have been achieved by re-forging the link between mother and midwife (Fleming 1998), an alliance that Kirkham (1996) suggested could prove powerful in developing midwifery in England, although this has yet to be fully realised.

A form of re-empowerment for midwives has been sought through adopting technology to expand the domain of midwifery, for example, suturing or scanning; also, a re-defining of the role of midwives towards 'obstetric-midwives' has been suggested (Fawdry 1994; Mason 2001). Some midwives were considered not to have 'noticed' a problem, appearing content to work in a subservient role 'under' medical direction (Clarke 1994) adhering to the rhetoric rather than reality of being '*practitioners in their own right*' (Davies 1996). Others tried to re-establish a more traditional role through independent practice (Kurutac 1994), a move inhibited by the subsequent raise in insurance premiums and the Royal College of Midwives' inability to provide such cover since 1995.

During this century the occupation of midwifery may have become recognised and achieved a certain status, some argued, as a semi-profession (Carr-Saunders and Wilson 1933, cited by Hearn 1982; Etzioni 1969). However, with the characteristics of semi-professions being defined as placing an emphasis on technical rather than theoretical knowledge, and, '*staffed mainly by women, managed mainly by men*' (Hearn 1982:197), serving to support the traditional patriarchal professions rather than achieving occupational autonomy, this did not denote any increase in power for midwives (Witz 1992). Whilst the

status of 'midwifery' may have changed, the position of the individual midwife has become increasingly less powerful, both socially and occupationally.

Kirkham (1999) has drawn parallels between modern midwifery in Britain and Freire's (1972) analysis concerning oppressed groups and their internalisation of the values of the dominant group; resonances of this were clearly apparent in the subservient role of the midwives working at the study site. However, the caseload midwives appeared to break out of this position, becoming more 'powerful' than their hospital or community colleagues. It is important to question whether this appearance was an illusion or reality. Did this model of caseload midwifery enable the midwives to have more 'power', and if so why? Where did 'it' come from, what was its nature, and what significance did this hold?

The Appearance of Power

Particular structural features of caseload practice indicated these midwives had been 'given' and were able to exercise more power in their work than their hospital or community midwifery colleagues.

Caseload midwives maintained a high degree of control over the use of their time. Only labour and emergencies overrode personal decisions about when and where they worked, although the possibility of either meant that while 'available' they were at the mercy of the ring from their mobile phones. Nevertheless, it was the phones that both symbolised and enabled their flexibility and appearance of being in control of their time.

The midwives had been given the choice and elected not to wear uniforms, unlike their colleagues in conventional practice who wore the midwives' uniform designated by the service. Not wearing a uniform proved advantageous in enabling the midwives to move freely between professional and personal activities. It also facilitated an increased personalisation of their work, as they moved from the 'role' of midwife to 'being' a midwife. However, for clinicians within this maternity service only those who were senior in the overall hierarchy (both medical and midwifery) wore their own clothes. Thus, in this setting, control over clothes could be equated with a particular position in a hierarchical structure and consequently significant of, potential, power.

A perception that caseload midwives were given more power by the Trust than their hospital or community colleagues was further supported by their public 'ownership' of clients, their caseload. Although for the duration of this study each woman was formally

allocated to a consultant, a feature the consultants had insisted on retaining, the caseload midwife's name also featured on the notes. Thus the individuality and responsibility of particular midwives was highlighted rather than subsumed, presenting the visible attribution of importance and power.

This 'ownership' in the form of responsibility for care, gave the midwives an authority which was reflected in changes that were made in the way caseload midwives were expected to operationalise the hospital system. They were able to admit and discharge women from hospital if 'normal', duties (or 'privileges') usually confined to medical staff. They gave 'instructions' to their colleagues concerning 'their' clients admitted to a ward, and liaised directly with senior medical staff rather than necessarily through the Senior House Officers. These two features in particular caused resentment amongst some junior doctors and some midwives, generating the *'elitist'* and *'superior'* comments made against the caseload practitioners.

Such 'structural' features could be viewed as indicators of the caseload midwives' change in status. Another signifier of such change, was caseload midwives featuring prominently in the annual Christmas review, both by performing as a group and as the focus of others' humorous attention. In this traditionally riotous performance junior doctors exhibit extreme license making fun of their seniors, in the classic *'permitted disrespect'* of the 'joking relationship' identified by Radcliffe-Brown (1952). A few midwives had previously played small supportive roles but reported never 'performing' as a group. As a new and high profile project caseload midwifery was an obvious target for sketches; nevertheless, for the caseload midwives to put themselves forward for ridicule was appreciated and, from comments made in later interviews, earned them the respect of the doctors involved. As identified in Goldberg's (1997) study of multi-disciplinary teams, joking created intimacy and denoted a lack of hierarchical difference; so the caseload midwives involvement in the review appeared to signify, and effect, a change of their status within the hierarchical organisation of the hospital.

In the sense of power being the ability to influence another's actions, the caseload midwives became more powerful as their communication skills improved. Unaccustomed to working politically, initially they were, at times, perceived as aggressive, which generated annoyance and irritation rather than co-operation and support. In learning not to antagonise, they became more effective in achieving their desired outcomes. This did not entail the development of strategies such as the 'hierarchy maintenance' skills noted by

Green *et al* (1986) nor the 'deference and proxy' discussed by Kirkham (1996), both of which maintain the original *status quo*, but the development of a more assertive attitude as the midwives gained in confidence from the new form of midwifery they practised. Particular features of the model enabled the caseload practitioners to be more powerful than their colleagues; however, the midwives had to learn how to use these wisely to be able to exercise power effectively.

AUTONOMY

One of the major attractions of caseload practice identified by the midwives was the ability to work autonomously. The 1982 Shorter Oxford English Dictionary defined autonomy as 'freedom from control' and 'self-regulation'. From their discussions, it was clear that the midwives were rejecting a system where they felt powerless, that their actions and decisions made limited difference and they were merely a '*cog in the wheel*'. Some also gave the impression that they did not necessarily respect those who held power over them, a situation also identified by Kirkham (1999). The desire was to move away from what was perceived by them as petty bureaucracy, rather than seek to develop personal power bases.

In the Weberian sense of power as being hierarchical, bureaucratic, and authoritarian, caseload midwives had indeed moved out of the dominance of the institution, as symbolised by the hospital walls. The immediacy of a hierarchy watching and dictating their every move had changed. Both the person and the role of their managers had altered, being replaced by a department whose philosophy of facilitation and enablement was radically different from the conventional service which maintained a Weberian approach to control (Weber 1978). Nevertheless, the wider structure had not changed and clashes occasionally occurred when the caseload midwives worked in the hospital. An example of this was the annoyance generated among both doctors and the midwife-in-charge when caseload midwives 'neglected' to keep the board updated on delivery unit. Other clashes developed when the project, at the end of the pilot period, was absorbed within the conventional management structure.

In seeking to provide a rational and impartial service, hospital midwives were governed by an institutional rule-bound power, enacted by a clearly defined hierarchy of office. Clear policies, procedures, norms and regulations controlled the midwives' activities. As individual 'agents' they exercise power but only within the possibilities generated by the

institutional 'structure'. Weber rather clearly described the hospital midwives' situation when he considered agents of bureaucratic power as:

'... a small cog in a ceaselessly moving mechanism which prescribes to him an essentially fixed route of march.' (Weber 1978:987-8)

For midwives, such control has been seen to inhibit the development and maintenance of skills in judgement and decision-making (Robinson 1989; Chamberlain 1996) and is recognised as stifling creative and imaginative thought (Kirkham 1999). It also appeared to contribute towards the development of a dependency relationship between hospital midwives and the institution. This was exemplified in the fear initially expressed by the caseload midwives and other professionals concerning their abilities to work in the new way. It featured in areas such as the hospital midwives' difficulties in coping with the disruptions in the organisation of the service with the implementation of caseload practice, and perhaps also in the reluctance of many to seek attendance on professional courses without institutional support. Without the 'back up' of the institution, in a variety of ways, the hospital midwives appeared to lack confidence in taking control of their midwifery role; they had been effectively disempowered, as described by Robinson (1989).

Autonomous, yet Controlled

Although the caseload midwives had moved both literally and figuratively out from the domination of institutional power, they still remained controlled by three separate mechanisms which sought adherence to overarching midwifery standards:

1. As registered professionals, each midwife was bound by the same laws and regulations relating to the profession as their colleagues working in any other style of midwifery service. The requirement to notify their intention to practice, adhere to the Midwives Rules and Code of Professional Conduct (NMC 2002; UKCC 1998), and fulfil the requirements for PREP (UKCC 2001) remained. As such, it should be noted that these are characteristics of controls on a profession rather than an 'occupational' group.
2. Although practising in a manner akin to independent midwives, the caseload practitioners were employed by the NHS. Thus adherence to the regulations and standards of the NHS Trust was required. Hospital protocols and guidelines were expected to be followed, and new procedures formulated as necessary. Initially this was undertaken by management but later by the midwives themselves, negotiating with the management and obstetricians. Adherence to employer regulations was important for

the midwives to maintain the vicarious liability cover provided for them by the service. Also, deviation from accepted practice could result in supervisory or disciplinary procedures being instigated by the midwifery management. In this instance, such features are characteristic of occupational rather than professional controls.

3. The third mechanism that controlled the midwives' practice and degree of autonomy exercised, related to their personal standards of practice, and to peer support and review. This can be understood as a Foucauldian definition of power, in the way tradition and enduring habit and assumptions are internalised and then govern people's behaviour (Foucault 1977).

In contrast to the more structural conceptions of Weber and Parsons, Foucault conceived of power as relational, being localised, dispersed, diffused, and disguised through social systems; operating at macro, local and covert level through sets of specific practices (Turner 1997). Central to these ideas was Foucault's conception of Jeremy Bentham's 1790 'Panopticon', the structural features of which enabled control of prisoners' time, space and movements, with the aim of maximising control through actual or imaginary surveillance. As individuals could be monitored at any time, they were forced to regulate their own behaviour. Foucault suggested power in modern society operated by the principles of the panopticon being institutionalised through every day routines and mundane arrangements (Giddens 2001). Power is thus embodied in day-to-day practices which produce particular individual, institutional and cultural arrangements (Turner 1997).

Whilst Foucault's ideas help explain the position and attitude of the hospital midwives, they also indicate a safety feature of caseload practice, highlighting the importance of the 'Awaydays' and peer review meetings to the establishment of a common philosophy and *modus operandi*.

The expectation was that the midwives would practice 'in the same way' as their hospital and community colleagues, in the sense of adhering to the same guidelines and protocols of care. The 'norms' of midwifery practice had not changed, merely the place and pattern of practising them. However, without a constant hierarchical presence, the midwives were able to exercise greater discretion over the implementation of care procedures, adapting them to the needs of individuals as considered appropriate. This also moved the midwives away from the Fordist NHS approach of seeing all staff as essentially substitutable by

another of similar grade; the individuality of both midwife and mother could be acknowledged.

Nevertheless, the fact that the midwives had internalised many of the conventional expectations was noted by student midwives, who expressed disappointment on finding the caseload practitioners were less radical in their practice as the students had expected or hoped for. It took time for the caseload midwives to break free from the modes of practice inculcated during their training and subsequent experiences, to take control of situations and to exercise authority; for example: recognising when a protocol was not suited to a particular situation and altering their practice accordingly – a characteristic which has been considered central to the ‘expert’ practitioner (Benner 1984; Benner *et al* 1996).

Participation in regular group meetings where practice was explored during peer review sessions was a requirement on the job description. The implementation team saw this as an important feature for developing practice. Such peer review sessions were, in reality, the formalisation of a characteristic inherent in midwifery talk: that of comparing experiences and cases. For Jordan (1989) such tales were considered important ‘*packages of situated knowledge*’ that were crucial when learning ‘what to do’ as opposed to the ‘how to talk about it’ lessons of more didactic, theoretical approaches to learning. Although Jordan was referring to training techniques used for traditional birth attendants rather than modern ones, Benner (1984) valued such comparisons undertaken in nursing as the construction of ‘*paradigm cases*’, used reflectively to help guide the ‘expert’ practitioner’s perceptions and action. Thus peer review, in the form of regular discussions about particular cases, was intended as a mechanism, advocated by Schön (1983), for helping the caseload midwives enhance their practice.

This took a long time to develop and be appreciated by midwives themselves. Submerged in a plethora of other activities, some midwives bemoaned the fact that peer review was ‘*always the last thing to get done*’. Regular sessions never became formalised in any of the groups during the study period, despite constant prompting and occasional leading from the practice manager. However, cases of particular interest were highlighted and formal reviews held on occasions. Also, observation of group meetings indicated that an element of peer review was conducted in an informal manner on many occasions, when individuals raised an issue, sought advice or queried practice.

Such practice within group meetings was observed on one occasion, as detailed in Box 4.

Box 4

Synopsis of interview and observation notes

During an exit interview with a caseload midwife the participant revealed what, as an experienced midwife, I considered a questionable practice concerning referral and post maturity. Immediately following this interview I attended the group meeting where this midwife handed over their caseload. This issue was quickly picked up by a member of the group and a robust debate ensued. Both students and midwives contributed to a detailed discussion concerning post-term referral, and group agreement over an acceptable practice was negotiated.

Field-note comment

A useful informal peer review session; safety feature; standardisation of group practice.

Source i. pm15.2 and field notes o.gm.'97

The degree to which the midwives participated in this discussion, obviously feeling confident to voice concern or opinion, was impressive. Such engagement discussing an element of midwifery practice had not been witnessed in the conventional service during nearly four years of personal practice or research activities. It was clearly indicative of the way in which the caseload midwives felt able to question each other's practice, and in a manner that helped maintain a particular standard of practice and enhance learning rather than criticise and demean a particular individual. The warmth and caring observed between group members clearly counteracted any '*corrosive*' (Kirkham 1999) effect of questioning practice. In accepting responsibility for personal practice as an inherent part of achieving autonomy, caseload midwives also learnt to take responsibility for each other's practice. In line with Foucault's (1977) ideas of power being relational, invested in and transmitted through social groups, the power of peer pressure, and accepted norms of behaviour appeared to form an important mechanism controlling standards of practice.

Autonomy as Team-Work

Initially some of the caseload midwives appeared to interpret autonomy as 'working alone'. Although linked with a partner, this relationship was relatively weak in such cases and, in caring for a personal caseload, these midwives aimed to provide 100% of care. With no clear guidelines, and being instructed to '*work out*' their own acceptable *modus operandi*, the midwives took time to learn the importance of team-work and to appreciate the wider structures for support.

Partnerships then became valued for the support they could offer – as an immediate source of advice on the end of a phone or as another ‘pair of eyes’, confirming or offering an alternative perception on a situation. Partnerships were also useful in helping to avoid building unrealistic expectations in women who had a tendency to become dependent on one individual; confidence in their partner also helped minimise the midwife’s feeling of guilt if they were not present at the labour and birth.

Over time individual midwives built up networks of information and identified sources of support for a variety of situations. These could, and were, passed around the group. For example, a relatively new caseload midwife, observed during a home visit, was asked about a particular religious ritual; she promptly consulted the ‘little black book’ passed to her by her predecessor to identify who in the area was suitable to be contacted. Although such knowledge was not part of the usual domain of midwifery, their ability to respond appropriately was considered important to the midwives and clearly valued by their women. Serving the needs of a diverse and, in some ‘patches’ relatively deprived population, over time the caseload midwives developed links within the wider community, the social services, and local health-care practices as well as individuals working within the maternity service.

Initially seeking autonomy as separation from the wider service, the caseload midwives found their ability to develop and sustain such networks fundamental to their work, providing crucial sources of support and power which enabled them to practice effectively. Working as part of a team has been a characteristic highlighted by several authors as important for modern professional ‘experts’; for example Stacey (1992) in her consideration of the British Medical Profession, Benner’s study of expertise in nursing practice (Benner 1984; Benner *et al* 1996), Stapleton’s (1998) work on collaborative practice and Bailes and Jackson’s (2000) analysis of home-birth. It became a key feature of the caseload midwives’ ‘autonomy’. Strength was recognised in numbers not isolation.

KNOWLEDGE

Obstetrics as the ‘Authoritative Knowledge’

Knowledge has long been recognised as an important source of power. For Parsons (1949), functionally specific knowledge, with 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 by shaping 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 challenge to the hegemony 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 Chapter Five, 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, *et al* 1996) 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 16,

contributed towards obstetric knowledge being the authoritative basis from which all staff worked.

Table 16 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 and 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 Lecturer-Practitioner 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. <i>Ad hoc</i> 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.

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 without 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 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

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 that different policies were 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 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 in Kirkham's (1996) exploration of the use of stories in childbirth.

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 in midwifery. This also 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 Seven).

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 (Menziés 1970; Benner 1984, *et al* 1996). 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' (Fleming 1998; Benner 1984, *et al* 1996) 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

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).

The Ill-Fit of Traditional Models

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 Two and Five, 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 (Bristol Royal Infirmary 2001; Diamond 2001), lead to public outcry and caused 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 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). Such a movement might also decrease the patient vulnerability identified by Atkinson (1995) in his study of the performance of medicine in an outpatient clinic. 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 experiences.

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 (Chalmers 1982; Williams 1993).

Even the expansion of knowledge is socially framed. Control over the focus of knowledge development has in the modern era, 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. Such social networks of control are contrary to the ideology that it is governed purely by experts.

Moreover, although, as Williams (1993) commented, there is no one 'ideal type' of profession and these may change over time, a key element of the professional-client relationship remains 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.RandD 1998).

In considering such a '*democratisation of science*' Bloor (2001) suggested it offered the potential to tackle public priorities, address public mistrust, and enrich scientific thinking by the incorporation of diverse perspectives (Irwin 1995). It would also challenge the

'gate-keeping' practices of professionals in knowledge acquisition – practices now partially breached by widespread use of the internet. Although a contradiction in terms, '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 (eg. 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 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*' (Bloor 2001:15).

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.

For example, 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, which incorporated both an ethnographic and trial approach, indicated that 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, perspectives which would not have emerged without the ethnographic component of the evaluation.

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).

Clearly, as Schön (1983:296) noted, practitioners must be '*credentialed, 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 during and after the use 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*' that Benner (1984) considered crucial to the expert clinician. From the Latin *cognoscere*, to know, Polanyi (1958) had considered this as an 'art of knowing' to be honed by experience under the guidance of a master, much as other skills such as wine-tasting are learnt. For Benner, in nursing this finely tuned skill involved 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, was a skill in clinical judgement that remained 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 offered greater potential for its development. As Meerabeau (1992) noted in her commentary on researching such expert, tacit knowledge in nursing, it is a difficult phenomenon to define and the acknowledgement of such '*professional wisdom or artistry*' is being 'squeezed out' with the implementation of service contracts. The caseload midwives did not initially have the 'guidance of the master' required by Polanyi, but in the relationship that emerged whilst providing continuity of care, they talked about developing a different understanding about midwifery and learning from the mothers themselves, particularly when caring for them during labour; knowledge that appeared more intrinsic than explicit in form.

Although the intuitive 'connoisseurship' expertise might not be achievable for all practitioners one of its components is integral to the new professionalism proposed by caseload midwifery. This involves more than the development and application of clinical

proficiency, to include the practitioner, in anthropological terms, actively seeking the emic perspectives of each client they are working with, and communicating 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 the 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 Korn (1964) in highlighting 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 17). 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 17 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

Freire, an educational philosopher, suggested that the usual ‘banking’ model of ‘oppressive’ learning (where students, deemed to know nothing, act as containers to be ‘filled’ with ‘deposits of information’ by successful teachers), should be replaced by a ‘liberatory’ ‘problem-posing’ one. This was based on a democratic relationship between teacher and student, an acknowledgement of their respective knowledge bases, and a partnership in which both were simultaneously teachers and students (Freire 1972). Although criticised for being idealistic and paternalistic, Freire’s ideas hold strong resonance with the different power structure and sources of knowledge in the midwife–client relationship that this study indicates are negotiable in caseload practice.

From this perspective, the most important foundation of professionalism becomes 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’ emerged as a important theme of caseload midwifery. In exploring the nature of modern professionalism, 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 for 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 a course of action that is considered dangerous by the practitioner. Whilst obstetricians can strongly advise a particular plan 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.

Sometimes 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 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 from the project-based Lecturer-Practitioner who accompanied those 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).

Such demonstrations of negative caring were not observed during the study; nevertheless, the potential cannot be denied. However, early in the project the midwives identified the danger of their clients developing dependency relationships. In strategising 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 is explored in detail in the following chapter.

CONCLUSION

In this chapter I have addressed the nature of power and professionalism in caseload midwifery. The analysis also indicated the ways in which power relationships within the institution may effectively disempower hospital midwives. This develops the theme outlined in Chapter Five of how, through the internalisation of such values, hospital midwives supported the medical hegemony.

Caseload practitioners were both symbolically and actually accorded some power by the institution through the organisational features of autonomy and responsibility. However, an ambiguity was inherent in any expectation that the midwives would practice in the same way as their hospital colleagues, merely transposing their skills into a different situation. The study indicated a very different phenomenon, with midwives gradually developing a new form of power. This was not immediate or inevitable, but took time as practitioners gained confidence in themselves and the mothers they cared for.

The centrality of the role of knowledge in power relations, and the development of graduate level midwifery education promoting a challenge to the medical hegemony, has been noted. Concurrently a new source of knowledge, and power, was identified as developing within caseload practice, facilitated by its particular organisational features. Being given sole responsibility for midwifery care midwives were motivated to address knowledge deficits and had time to access relevant sources; they had to apply their knowledge, situating it in a variety of circumstances, and were able to evaluate and reflect on their practice. Also the project promoted a philosophy of questioning and learning from each other as the practitioners developed a body of midwifery knowledge. More fundamentally, over time the midwives developed a sense of authority concerning the mothers on their caseload; they learnt to trust the mothers, to accord them respect and finally began to learn from them.

I have argued that caseload midwifery engendered a new form of professionalism based on positions of equality. This acknowledges client participation as integral to a relationship that promotes the sharing of knowledge and in which theoretical perspectives no longer dominate but support that relationship. However, for such truly equitable relationships to flourish, Frankenburg (1992) has suggested that the phenomenon of time must be addressed. Identified as being fundamental to the nature of caseload midwifery this concept, and the implications of the ways in which time was used, form the subsequent analysis of caseload practice, presented as Chapter Twelve.

Chapter Twelve

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)

INTRODUCTION

The above quote aptly highlights a fundamental difference between institutional birth and that facilitated by caseload midwifery practice. This chapter explores the different approaches to time that were observed within the hospital and caseload practice, and develops an understanding of how issues concerning 'time' were used as mechanisms for controlling childbirth. Such perspectives, although found to be fundamental to the nature of midwifery practice, are deeply embedded in the social life of the service and are unlikely to be tapped by positivist inquiry. This again highlights the value of the ethnographic approach, enabling identification and exploration of this theme.

The organisational features of caseload midwifery facilitated a very different orientation towards time that held both advantages and disadvantages for the practitioners. However, this difference also created problems, issues relating to 'time' being the unrecognised basis for some of the conflicts the midwives encountered during the implementation stage. To fully appreciate the differences 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 phenomenon of 'time', and the way it is both perceived and measured, is constant throughout 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, a native American group studied by the anthropologist and linguist Whorf, they were found to be embedded in their social life and behaviour rather than externalised as a precise category; they had no word equivalent to our 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 interweaved 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 simply '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 (Bohannan 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 culturally specific notions about time, childbirth carries its own time – a physiological-time. The mother 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 conscious 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. Drawing from a number of disciplines, theoretical stances and empirical studies, Hall considers the notion of time and the ways this may influence a society. Using a comparative frame, he develops a thesis suggesting that time is not only a '*silent language*' that '*speak(ing) more plainly than words*' (1959: 23) structures behaviour and the judgements made about that behaviour (1969), but also influences cognition and the manner in which societies relate to their physical world (1976). His work is broad in argument and eclectic in nature, lacking original empirical evidence, but offers invaluable insights into ways of considering social situations. For example, the 'task-orientated time' of pre-industrial societies, detailed above, is closely related to Hall's notion of polychronic 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 monochronic 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; eg. 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 polychronic 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, and whose personal-time was 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 a 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 schedule. 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 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. However, physiological-time cannot be overruled 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 Four).

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 followed. Perceived delays in progress were quickly noted and intervention recommended – a system not just dependent on obstetricians' 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 control of time, for example by not confirming full dilatation immediately when 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*'.

The possibility of complications 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 divisions, 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 37½ 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 commoditisation 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. Scheduled '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 18.

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.

Table 18 A comparison of orientations towards, and use of, time for Midwives

Hospital Midwives	Caseload Midwives
Contracted for 37½ hours 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 and personal life.	Work ‘embedded’ in personal life.
Request particular days off.	Negotiate free time with partner and 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.	<i>‘Long hauls’</i> and quiet periods when minimal work. Can use to personal advantage. Reported to balance over time.
Work ‘time’ directed and 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.

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'* (ie. 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 (eg. 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 periods 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 Six, 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* being described laughingly 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 often 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 –

(implied – to complain to). *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.'97.pm31)

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 24-hours 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 7:

Box 7

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'.

CONCLUSION

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. This understanding of the way time was used, both within the hospital and when carrying a caseload, helps 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. This analysis indicates why caseload practice is not suited to all practitioners. Personal characteristics or circumstances may result in unacceptable tensions when working with more 'traditional' concepts of time, suggesting that the model should not be imposed on midwives. The viability of the model *per se* is considered in the subsequent chapter.

PART FIVE

THE SUSTAINABILITY and IMPLICATIONS OF CASELOAD MIDWIFERY

Overview

Although caseload practice clearly increased the 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 of the sustainability of caseload midwifery practice, and the implications of this for the maternity services, form the focus of this last part of the thesis.

In Chapter Thirteen, consideration will first be given to the midwives' view of the service and the reasons why some left. These reasons will be seen to be multifactorial, involving an interplay between personal and organisational issues. However, there is some indication that the personal characteristics demanded of and honed by difficult change processes are not so important for subsequent service development. As these 'change agent' midwives may leave seeking challenges elsewhere, caution is advised in drawing conclusions from this limited data concerning the sustainability of the model *per se*.

The evaluations of other models of care introduced to benefit mothers and midwives are then considered in relation to the understandings generated from this study. Many problems with such schemes have been reported. However, a review of the evidence highlights the inadequacy of these evaluations. The comparative analysis offered here suggests, given particular organisational features, very different outcomes may be achieved from continuity of carer schemes such as caseload practice.

The final chapter presents a synthesis of the themes that have been developed through the thesis and considers the implications of caseload practice for maternity services. The strengths and challenges of this study are reviewed and the questions it has generated, posed.

SUSTAINABILITY OF CASELOAD MIDWIFERY

INTRODUCTION

This chapter addresses issues about the sustainability of caseload midwifery from a variety of perspectives. The views of all the caseload midwives are presented and the reasons given by those who left the project are considered. A critical review of the findings of alternative continuity of carer schemes is offered using the understandings generated by this study. Finally, the organisational features that contributed towards the sustainability of the model are identified.

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 19 and 20 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.

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.

Table 19 Perceived strengths and weaknesses of the current service

<p><u>Positive Features</u></p> <ul style="list-style-type: none"> • 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 <i>Changing Childbirth</i> Co-ordinated multidisciplinary care meeting client needs and preventing duplication Motivated midwives <p><u>Negative Features</u></p> <ul style="list-style-type: none"> • 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
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Source 1997 Questionnaire response nos. 30/35

Table 20 Summary of midwives' views about working in the caseload service
(positive and negative points identified)

<u>Positive Points</u>	<u>Negative Points</u>
<p><u>Current midwives</u> (no.19+3 maternity leave)</p> <ul style="list-style-type: none"> • Relationship with women and 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 and shared philosophy • Flexibility of working hours • Job satisfaction • Variety – clinically and cultural mix of clientele • Working in community • 'Being a person' <p><u>Leavers</u> (no.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 and management • On call • Uncertainty about future of project • Demanding women • Long hours • Conditions of service (eg. pay and holiday, smaller caseload; problems with lease cars and 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 and time

Source 1997 Questionnaire response nos. 30/35

Why Midwives Left

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, twelve 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 effect 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:

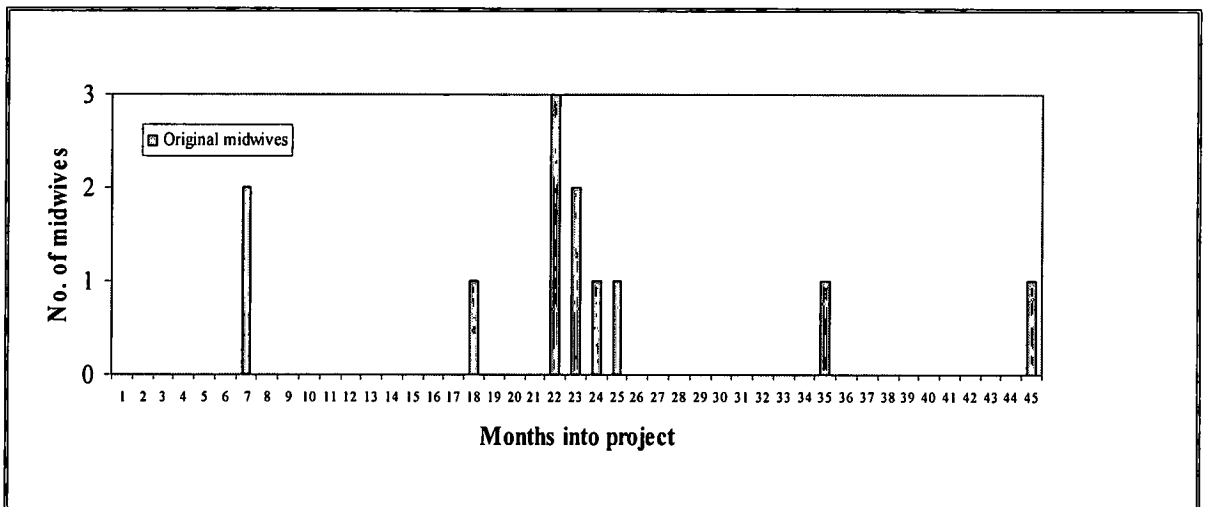
- One left after three months, having been awarded a fully funded place, previously applied for, for Health Visitor training; this person was not included in *any* data collection because of their short duration in the project.
- One person employed on a temporary contract covering maternity leave, left 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 21, highlighted that two midwives left after seven months, during the transition period before they had learned to ‘make the job work for them’ (see Chapter Eight). They clearly felt unsuited to caseload practice. Also, seven midwives left during the period August 1995 to December 1995. 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 21 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 (three) 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 (two original, one 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 (eg. 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*', 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.'* (all 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 area 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! (stated 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?

This ethnography has been able to inform aspects of these questions, offering the perspective of caseload midwifery practice as experienced in one 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 should be unique, designed for specific populations and situations, although they are likely to share themes. Nevertheless, the findings of this study help to address some of the questions raised by other studies of midwifery practices, and are now considered in the context of the sustainability of this and other such models of care.

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 three issues became apparent:

1. 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.
2. The adaptations demanded of the midwives in changing their style of practice took time; the 'transition period' for the 'original' midwives was considered to last approximately ten months (Chapter Eight).
3. 'Problems' found in other pilot schemes were also identified in caseload practice. They required specific acknowledgement and strategies were successfully developed to avoid or overcome them, as indicated in the following examples.
 - Allen *et al* (1997) noted that 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, emerged as being 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 were considered by the midwives not to have 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 the boundaries and approaches they considered most appropriate.

- Allen *et al* suggested that '*potential resource implications were very high*' if midwives provide 24 hours on-call cover for their women (1997:233). They noted this had been resolved in one situation, the project studied here, by a negotiated salary enhancement that was considered an important modification. The understanding from this ethnography supports that statement. Issues relating to use of time and control of time were fundamental to caseload practice (*see* Chapter Ten). 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; such high levels of satisfaction 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 act as 'change agents' and might move on once the initial challenge diminishes, as detailed earlier in this chapter. 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; positive changes with continuity and, in some areas, improvements increasing over time were indicated (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. This ethnography has indicated how organisational features enhance or constrain personal characteristics (*see* Chapters Ten, Eleven and Twelve). 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 it enables such midwives to be retained within the profession.

Minimal Change and Misleading 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 Two. 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 (Guiland 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). Schemes introduced with relatively minor changes, such as hospital-based teams designed to minimise colleague disruption, merely 'tinkered 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:

1. 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.
2. In a normal delivery the mother delivers her baby, assisted by the midwife.
3. 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 3), 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. This 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 1993:15; 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 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); an idea that holds resonance with Maslow's hierarchy of needs, as described in Chapter Ten. 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):

- Every woman should know one midwife who ensures continuity of her midwifery care – the named midwife (No.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 (1997:30) 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 (eg. 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 Ten.
- On a more practical level, mothers generally 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 deeper 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 (eg. 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 – or in every context.

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 concluded 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 – 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 invariably 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 evolved 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 such flexibility is important.

A supportive and facilitative rather than controlling management ethos, structure and philosophy of practice were central to the model to encourage a sense of ownership amongst the midwives. Organisational features that promoted autonomy, responsibility and continuity of care 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 a vibrancy within the midwives' practice. The provision of appropriate administrative, practice and management support was necessary to enable the midwives to function appropriately.

The findings indicated that 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 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, is likely to do little to promote professional confidence and development.

This style of working clearly 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 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 contributes 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, *et al* 1996) 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.

CONCLUSION

It is clear from their questionnaire responses that the caseload midwives valued this model of practice as they had experienced it and as understood in the analysis presented in this thesis. However, they equally clearly identified problem areas. Whilst it is likely that the positive features they highlighted are generic to the model, those identified as problematic encompassed both local and generic issues.

Some of the problems that were specific to the locality have been resolved, for example, the eventual combination of the two maternity units on to one geographical site. Other difficulties would probably be similarly experienced, and resolved, elsewhere eg. the introduction of hand held notes overcoming problems with hospital-based clinical notes. Nevertheless, interpersonal conflicts and lack of organisational support are suggestive of enduring problem areas inherent in the model; these need to be addressed wherever caseload practice is implemented.

Evaluations of other continuity of carer schemes have indicated such problems in creating an acceptable balance between providing continuity for women and midwives having time off, that the importance of providing continuity for mothers has been questioned. However, these studies indicate a wide disparity in organisational features and definitions of continuity. When the question is reversed, and the meaning of continuity for midwives is considered in the light of this study, it is seen as fundamental to their job satisfaction.

Nevertheless, the sustainability of caseload practice is reliant on particular organisational and philosophical features. A supportive and facilitative, as opposed to controlling, management and a philosophical ethos that promoted enquiry and learning were identified as crucial factors. Autonomy, responsibility, continuity and flexibility were seen as symbiotic and iterative providing the strength of caseload practice. Such features formed a sustainable 'package'. The implementation of only parts of this package alters the balance and is likely to generate stress and ultimately prove less sustainable.

CONCLUSION AND IMPLICATIONS

INTRODUCTION

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 WÍF TO MIDWIFE TO MID WÍF – 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 parameters 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 work. It gives meaning to the midwives' practice as familiarity with particular situations expedites the provision of appropriate care. Repeated contact enables assessment of that care, allowing for 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 locus of control from institution to midwife, caseload practice facilitates a movement for mother and midwife from positions of subservience to one 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 was never observed. 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, eg. 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 wif', 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

A 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.

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 '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 styles 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 having 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: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 Eleven).

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 Part Two. 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 collection 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'. This 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 (eg. 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 Six.

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 highly 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 quote a popular saying, the understandings gained from this study strongly support the thesis that in midwifery, 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

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

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 of 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 the 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 the 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 the 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:/wrldmd.ent

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:/wrdrod.cnt

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.

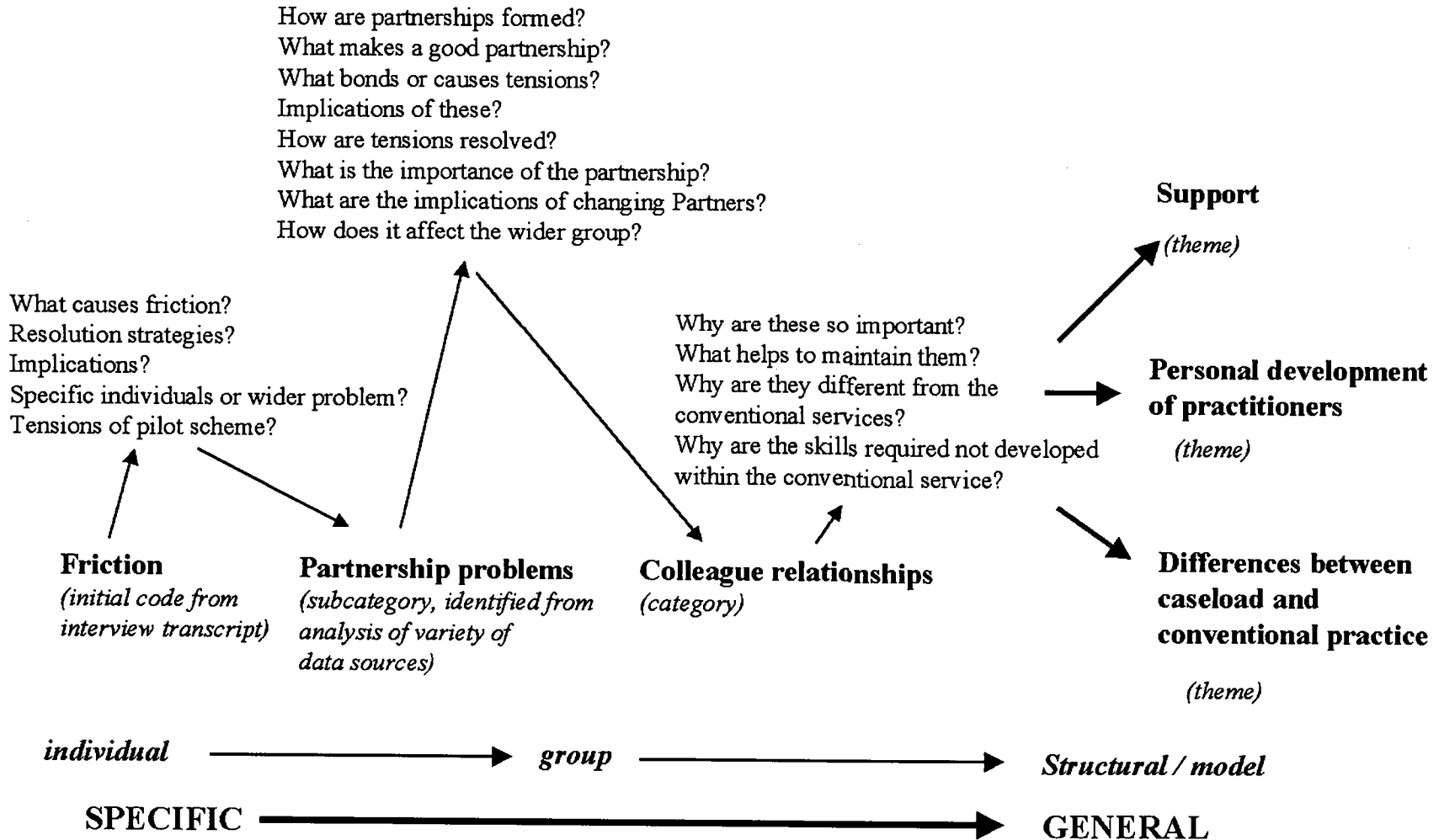
The group arranged that we all meet in house on 27th August, from 12.00 - 14.00 so we can have a relaxed and informal discussion. I will help to provide some lunch. This is an important meeting and I do hope that you will be able to come; please try to block the time out. It is an opportunity for you 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

Appendix 4b Diagram of a sequence of the analysis.

This illustrates the dialectic between data and analysis and the movement from individual to general perspective.



CLARIFICATION OF TERMS

Concepts central to the study are defined here in acknowledgement of the degree of confusion over the definitions used in the literature.

'All care'

One midwife cannot provide all midwifery care for each woman. Unplanned events such as premature labour, admissions to hospital where 24-hour 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.

Caseload

One midwife is responsible for the midwifery care of a defined number of women per year, assisting the mother before, during and after delivery, wherever necessary. 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).

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, eg. 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.

Integrated

Care is undertaken in both community and hospital situation 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.

'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' is used when referring to the caseload midwives to avoid misunderstanding.

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' epidurals involve using particular drugs with the aim of maintain mobility yet achieving 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 professional that provides care. Information stays with the mother, not stored in a hospital medical records department.

Home birth Birth is planned to take place at home, usually 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 lead professionals do not necessarily provide the 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; this 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.

Postmaturity The baby has not been born after the due date has passed.

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'.

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.

Shared care Care is provided by GP and obstetricians.

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 delivey 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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