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Thomas, B. Gail (2003) Learning to be a Midwife - The Need to Believe. Doctoral thesis, Thames Valley University.

10.36828/xvqy1553

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Learning to be a Midwife:

The Need to Believe

B. Gail Thomas

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

August 2003

Acknowledgements

There are a number of people who deserve my heart felt thanks in relation to this project.

Firstly, I would like to thank all of the midwives who participated in the study; their willing sharing of experiences and thoughts has provided me with insights and incentives I never would have found on my own.

Secondly, I wish to acknowledge the support and wisdom shared with me by my supervisors- initially Professor Lesley Page and then Dr. Chris McCourt from Thames Valley University and Professor Mavis Kirkham from the University of Sheffield. They provided sources of inspiration and connection.

Thirdly, I would like to thank all my colleagues at TVU who have encouraged and supported me throughout. Specifically I would like to thank Sarah Beake who collated findings from educational studies so I could analyse them and use them in this study.

Lastly, but certainly not least, I thank my husband and sons, Bill, Ben and Sam. Their tolerance and belief in me through this period has helped to see me through.

Dedication

I dedicate this thesis to the memories of my beloved parents- Stanley Charles and Helen Margaret Amey. My father never knew that I would undertake this project but it was his early challenge that led me to pursue doctoral studies. My mother was very proud of my plan to do this project but sadly is not here to share in my success.

Abstract

This thesis records the progress through a four phase grounded theory study, leading towards the development of an educational strategy for pre registration midwifery programmes. The starting point was the recognition that students of midwifery are not always enabled to learn how to use the skills of woman-centred care, often adopting the norms of contemporary practice in which there may be conflict between the needs of the organisation and those of the client. The aim of the project was to develop an approach to education which would be based on evidence and which would help students to become woman-centred in their practice.

There are three literature reviews presented, those of the history of midwifery, current concepts in the midwifery literature and research into teaching and learning. The outcomes of these reviews demonstrated a lack of clear midwifery-specific theory on which to base the educational strategy and some inadequacies in the current approaches in education. The research conducted, as a result, aimed to identify the key concepts on which programmes of education should be based.

The first of the four phases of the research entailed individual interviews with fourteen midwives working in an NHS maternity unit. These midwives told stories of positive experiences when supporting women but also experienced frustration at times when they felt that colleagues had taken charge of the care they provided for women. The effect of working in a large bureaucracy prevented them from consistently supporting women in the way they felt was optimal.

The second phase involved interviewing a selected sample of 'autonomous' midwives who had moved out of traditional maternity services in order to be able to practice in woman-centred ways. These interviews were conducted individually or in small groups, based on availability. These midwives presented a very different image of midwifery, one where they really seemed to believe in normal, physiological birth and in their ability in supporting

women to achieve this. The question as to why these two groups appeared so different arose.

In the third phase, personality tests were administered to the two groups to try and control for differences in personality traits, using the Big Five Inventory. This demonstrated a statistical difference in the trait of 'openness to new experiences', with the autonomous group being more open than the initial group interviewed.

In the final research phase, the autonomous midwives were asked to consider any critical events in their personal or professional lives which may have contributed to their desire and ability to practice autonomously. The findings included a strong personal ideology, frustration with the status quo and, in contrast, the experience of positive role models; these factors had led to their belief in women's capacity for normal birth and in the contribution of midwifery to that end.

The findings from the literature and the four phases of the study have been integrated into a strategy for education, based on the need to develop students who 'believe'. This needs to be set in the context of current bureaucratic maternity services, recognising that students experience their practice-based learning in these environments. The challenges associated cannot be under-estimated but a variety of tactics are proposed as means to helping students to overcome negativity and to develop both the skills and commitment to woman-centred values.

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Introduction to the Study –
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Background

This chapter introduces both the study undertaken and this thesis. It provides a personal justification for the project, a rationale for why this work is and was important to me as a midwife, an educator and a woman. It describes the journey I have travelled over the six years since its inception, identifying the key points along the way. It helps to set the scene and provide a clear picture of the structure of the thesis so readers are easily able to find their ways through it.

When I began to think about doing a piece of research for my doctorate, I wanted to look at an area which brought together my fields of interest, those of both midwifery practice and midwifery education. The path of learning to be a midwife was one that had been little researched at the time; therefore this was chosen as my starting point. As a lecturer in midwifery, with the majority of my experience having been in pre registration programmes for already qualified nurses (the shortened, 18 month programme), I felt that we did not always successfully help students to move from their nursing background to a midwifery paradigm. My perspective of this midwifery paradigm is supported by many writers in the field and includes the view that pregnancy is a state of health (Harding 2000), birth is a normal, social event (Bryar 1995) and that midwives and women are equal partners in a relationship of purpose (Newby 1990). Midwifery practice is based on an holistic perspective and is believed to encompass "the social, emotional, cultural, spiritual, physical and psychological aspects of the woman's childbearing experience" (Harding 2000:75). My thoughts were that nurses, who may have practised in very different contexts to that of positive health and social change surrounding birth, may need help in seeing things through different eyes. I believed that we seemed to assume that the students would take up woman-centred values without deconstructing previous experience, which may possibly have related mainly to ill health and the hierarchies of the health service. Nor did we seem to

actively make explicit the ideals of the profession, facilitating their integration into effective midwifery practice.

I reflected on my own experience, having been a nurse for eight years before moving into midwifery. It was only several years after qualifying as a midwife I realised how much I had changed from those nursing days, possibly more by serendipity than intention. I had developed an understanding about birth that had not been made clear to me during my training, that is, that it can be much more than a physiological event or a social transition. It can be an empowering event for women which can give them strength and confidence, setting them up to be able to navigate the world of motherhood with new found inner resources. Much of my reflection came from my personal experiences of birth, both of which had been incredibly satisfying events which had made me feel that if I could have a baby, I could do anything! I had four other particularly relevant experiences on which to draw in my reflection; I had supported two close friends with each of their two births. Their reactions to my support helped me to realise how important it is to connect with the labouring woman in a way that I had never been formally taught.

We cannot expect all midwives to have experienced birth, nor that those who have, will have had similarly positive experiences to those of myself or my friends. But my belief was that educationalists should be able to provide students with learning opportunities that would help them to realise the powerful potential of the childbirth experience and how important the midwife's role is in creating an environment that leads to this empowerment. It seemed important to remove serendipity from the process, to plan for students to have experiences that would help them to feel the way I did. I wanted to be able to make a difference for students and ultimately for the women they supported through the childbearing process.

However there is a need to consider the actual possibilities and purpose of education in this process. Can an educational programme realistically make such a profound difference, recognising that contemporary British midwifery practice exists within a very defined culture? I have worked with many midwives over the years who seemed to have very different impressions of the possibilities of birth. As Hunt & Symonds (1995) found in their research in labour wards, many midwives just try to 'get through the

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work'. In other words, they perform a job, an important and necessary one, but not one with the passion and potential that I feel is associated with midwifery. Midwives are not in a particularly powerful position in the contemporary hierarchical and medicalised maternity service in Britain (this will be discussed in detail in chapters two and three). If the programme of education sets expectations for students of midwifery which are not realised in the practice they see in maternity units, does this help them to become different to the norm or set them up for disappointment? Is it fair to use students as agents of change, enthusing them with hopes of a 'new midwifery' (Page 2000) that is not the reality they experience in practice? If they start their careers with a set of values which does not necessarily meet those of the others in the unit where they work, are they able to continue to practice true to those values or do they 'go native' as the path of least resistance?

I wanted to believe that education could be a powerful mechanism in a process of change but needed to explore in depth the evidence of the possibilities. I also needed to identify whether my personal perspectives on midwifery were valued within the midwifery community and valid as midwifery constructs.

The Journey

I began my journey with reviewing a substantial body of midwifery literature. An educational strategy should be based on sound evidence; what was the theoretical basis on which I should build this strategy and how did we know it would achieve the 'right' sort of midwife? This review began with a study of the historical development of midwifery, primarily in the U.K. but drawing on appropriate international experience. This is presented in chapter two and sets the context for the culture of midwifery within the National Health Service, in which students of midwifery currently learn to practice. I went on to look at what midwifery authors of the day were writing about as important concepts in midwifery (1996, see chapter three). The literature at the time reflected the growing interest in research in midwifery but also included a lot of opinion papers on the lack of explicit, empirically-derived midwifery theory. Concepts within midwifery were discussed, for example communication, choice, control, continuity. But, largely, theory for midwifery seemed to be borrowed from other disciplines - nursing, medicine, physiology, sociology, psychology, health education (as discussed, for example by Bryar 1995). This phenomenon led me to question the theoretical foundation of

midwifery; how had we developed as a 'profession' (if indeed midwifery is a profession, discussed in chapter two) without a discrete and codified body of knowledge? Knowledge must be implicit in midwifery practice but there appeared to have been little attempt to make the unique characteristics of it explicit in a recognised, formal manner at a theoretical level. Possibly more importantly from a personal view, how could I develop an educational strategy if there was limited evidence as to what the key concepts underpinning it should be?

I next critiqued some theories of education and learning, and then reviewed the research evidence in relation to effectiveness of midwifery and nursing education. This review is presented in chapter four; there are some rigorous studies of the effectiveness of midwifery education (notably Fraser, Murphy & Worth-Butler 1997) but there are also many criticisms with the current methods of teaching students of midwifery. This was important; the strategy I was to develop should be based on evidence of effective ways to support learning as well as on sound midwifery theory.

The three literature reviews in this thesis have been undertaken in different ways as they have served different purposes. The historical review in chapter two is intended to be contextual; the approach used has been a descriptive one using a variety of sources to highlight the development of midwifery in the Western world, primarily in Britain. There was no attempt to be exhaustive in this review as its purpose was to paint the background picture of the development of contemporary practice.

In chapter three, the findings of the initial review undertaken as part of developing the research proposal are presented in the second half of the chapter. The purpose of this review was to articulate the midwifery theory / key concepts on which the educational strategy should be based; the review therefore includes a diversity of sources writing about midwifery at the outset of the project. This includes empirical findings as well as opinion papers, as so much of midwifery practice remained un-researched despite discussion about its significance being prevalent. However, the review helped me to realise that there was insufficient explicit theory on which to base the strategy. Therefore data collection and analysis began shortly after completing that review. In returning to it a few years later when writing up the thesis, it became obvious that some issues and priorities had changed in the intervening period. Therefore the first

half of chapter three identifies additional concepts which were impacting on midwifery practice at the time.

The fourth chapter presents a review of both the current drivers and imperatives in British midwifery education and research into midwifery and nursing education. The section on the research is structured and extensive; it provides a comprehensive review of studies undertaken in midwifery (with additional relevant ones in nursing) to identify the significant issues in the learning of midwifery students. As the educational strategy was intended to be empirically driven, it was felt important to include all the research undertaken at that point as a sound foundation for the way forward.

As a result, the reader will identify some difference in approach in these three chapters. Chapter two is primarily descriptive to set the historical and political scene, chapter three is fairly free-flowing to identify the issues which writers are and were feeling as important in midwifery and chapter four is much more extensive and structured to provide a solid framework for the educational strategy.

With the background having been established (history of midwifery, key concepts from the midwifery literature, theories and evidence in relation to learning), the first research step in the project seemed to be to try to identify elements of the midwifery theoretical base. I needed to learn more about the basis of the occupation as the foundation for the educational strategy and to confirm whether or not my constructs were valued by other midwives.

The Research Questions and Process

As a midwifery educator and practitioner (regularly if not frequently practising), I started this project with assumptions and beliefs. It was an important part of preparing to undertake the research to reflect on my personal and professional values and to make these explicit to myself in an attempt to minimise my influence on the direction of participants. Therefore, before undertaking any data collection, I used a repertory grid approach (Kelly 1955, Kirkham 1995) to define my personal construct of midwifery (see appendix 1). This exercise helped me to clearly articulate my values; in so doing I was able to identify potential bias as an important part of reducing possible personal impact on the research subjects (see chapter five for discussion on 'practitioner

research'). Throughout the project, I kept a reflective diary in which I returned to that initial construct on an ongoing basis and listened to the data collected repeatedly to determine whether I was directing the participants' words. It proved a useful learning opportunity for me; at times, it seemed that the midwives interviewed did say what they felt I wanted to hear (also discussed in chapter five). However the vast majority of the data appeared to reflect their real worlds rather than any ideal which they might have articulated for the researcher's benefit. Having undergone the initial reflective exercise, I then considered how best to undertake the research that would help to develop an educational strategy.

The methodology of the study and methods used for data collection and analysis will be discussed in depth in chapter five; however the key research questions and how they were developed are presented here in order to provide an initial explanation for the journey I travelled during this project.

Question One - What is unique about midwifery which students must learn?
Question Two - Why are some midwives able to practice 'autonomously' in a way which helps women to achieve the birth experience they want? Are they different types of people?
Question Three - Have there been any 'critical events' in the experiences of the group of autonomous midwives interviewed which could be replicated in an educational programme?

Question One - What is unique about midwifery which students must learn?
Having identified this as the first question, I had to decide how to try to answer it. With such a broad starting point and no hypothesis to test, a qualitative research approach seemed the only possibility. Grounded theory was chosen as the framework and methodology as its purpose is to generate theories and theoretical frameworks (see chapter five). As it seemed that an explicit, formalised and articulated theory of midwifery was largely lacking, I refrained from defining a specific theoretical framework as a starting point. I wanted to avoid imposing a perspective which would colour my findings, preferring to be open and receptive to the theory which would unfold and be grounded as the study progressed. I began data collection, with contemporaneous analysis, by interviewing individual midwives about their understanding of midwifery.

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Stage one of the project entailed individual interviews with fourteen midwives in a maternity unit. This unit was local to me, had a reputation as a fairly midwife friendly one (as opposed to obstetrically dominated) and had a team approach to midwifery practice. Equally important, the Head of Midwifery was supportive of me doing the research there and I was able to get ethical approval for the study.

I interviewed four midwives in the first instance and then identified issues and themes coming out of the interviews. In the next four interviews, I tested out the themes that had emerged in the first ones by asking related questions to determine whether these midwives also believed these issues to be important. This led to the collection of data which helped to densify these themes and which introduced some somewhat different ones. This process was repeated with another four midwives; the themes emerging were becoming saturated. I finished this stage with two more interviews from which no further new themes were emerging.

I have called the three themes 'making sure', 'preparing' and 'making a difference' and they are discussed in detail in chapter six. Despite these midwives having a lot of positive stories to tell about their roles, the overall impression was one of relative powerlessness in their situation. I had learned about some important concepts in midwifery, both positive and negative, but I felt I needed to interview a different sample to get a perspective on midwifery from a group who felt much more in control of their practice.

Stage two entailed individual and small group interviews with nine 'autonomous' midwives. This was an opportunistic sample of well known midwives who practised out of the normal maternity services e.g. caseload or independent practice. My supervisor was able to put me in touch with some internationally very well known midwives as well as local ones; I interviewed them whenever they were available in whichever means was appropriate (that is why some were individual and some were in small groups). In these interviews, I tested the themes from stage one. These midwives understood where the themes had come from but mainly saw things differently; analysis showed that they believed they could make a difference and weren't constrained in the same way by their environment as the initial group appeared to have been. Their passion

and enthusiasm for women, birth and midwifery was awe-inspiring. I believed it was clearly something that would be an ideal to develop in students of midwifery. This stage of the project is discussed in detail in chapter seven.

The data I had collected was rich and fascinating; I had identified a lot of important issues so far. But I was unsure as to where to go next; in grounded theory, the data and ongoing analysis is meant to lead you to your next sample but the direction, at that point, was very unclear to me. I went down two 'blind alleys' at that stage; first, I interviewed a group of new mothers. They had many interesting things to say about their birth experiences but it was impossible to integrate their issues into the findings to date. I was getting farther away from the key concepts of midwifery and even more so from the issues relating to the education of nurses as midwives.

The second 'blind alley' was two focus groups with student midwives. Once again, their points were interesting but did not help to make sense of my findings from the first two stages. I paused for some time to try to find my way and met with a number of other researchers, read several other theses and grounded theory studies and reflected considerably, writing extensively in my journal. Finally I realised that, rather than going on to a new sample, I would be best placed to return to those I had already interviewed and ask different questions of them. I also realised that the issue of nursing prior to midwifery training was no longer a central feature; the theory which was being developed should be important to all students of midwifery regardless of their previous roles.

Question Two - Why are some midwives able to practice 'autonomously' in a way which helps women to achieve the birth experience they want? Are they different types of people?

During my reflective period, when discussing my findings with my supervisors and a variety of other researchers, a particular issue was raised repeatedly. Were the midwives in the two groups of interviewees different types of people? Were they practising in different environments as a result of that basic difference? Or did the environment help to shape the kind of person? My first reaction was to dismiss any attempt to try to answer these questions as I was aware of the scepticism about both the concept of personality and the ability to identify traits through testing. However, it

seemed that the questions would always remain if I made no attempt to identify any key differences in these two groups of midwives. Although personality cannot be considered as a purely genetic construct, an exploration of possible differences as a control for any major personality distinction appeared worthwhile.

Despite my uncertainty about the issue of personality and its testing, having spent considerable time with the psychology literature and a psychology colleague, I felt there was sufficient evidence of the effective / potential use of personality tests to try and compare the two groups' basic personality traits. If I didn't try to assess whether they were different types of people, the question may always remain and detract from the legitimacy of my findings, as many of my colleagues had identified. Therefore, stage three of the project was to undertake personality tests using the 'Big Five Factors' (agreeableness, conscientiousness, openness, extraversion and stability) to try and determine whether there were any clear differences between the two groups. This will be discussed in detail in chapter eight.

Some three years had elapsed since I had begun the first interviews; I had to try to find a number of the midwives who had moved on in that period. I was able to locate and get responses from eleven of the initial fourteen and eight of the second nine. The results of the personality tests showed a statistical difference in only one factor, that of openness to new experiences, with the second group scoring higher. The implications of this needed to be considered for the educational strategy but, without a dramatic difference demonstrated between the two groups, other factors needed to be considered to identify why the groups presented so differently.

Question Three - Have there been any 'critical events' in the experiences of this second group which could be replicated in an educational programme?
The fourth and final empirical stage of the project was to ask the second group to reflect on critical events that they felt had contributed to the way they practised midwifery. I asked them to tell me stories of anything in their personal or professional lives that helped to shape them into the type of midwives they had become. Once again, data were collected in a variety of ways as these midwives were all around the globe. My first request was that they either wrote or taped their thoughts and send them to me. This was only partially successful and I had to adopt different approaches

to get the data I sought. Two wrote and emailed to me succinct accounts, one taped a long account of her personal history which was transcribed, I conducted a telephone interview with another and personal interviews with two more, all of which were recorded and transcribed. Despite several requests to the remaining three, I have not been successful in getting their stories.

The analysis of these accounts helped to confirm the themes which had emerged from the earlier data collected. These midwives articulated a strong personal ideology, some explicitly as feminists, which helped them to believe in women. Both their experiences of midwifery in the maternity services and powerful role models led them to believe in themselves as well. Their belief appeared to give them the confidence to be very woman-centred despite the environment and other external influences. This discussion is found in chapter nine.

The Thesis

This thesis presents, in detail, my journey. Section one focuses on the three initial literature searches, one relating to the history of midwifery (chapter two), one to contemporary concepts in midwifery practice (chapter three) and one to midwifery education (chapter four). It also presents the theoretical framework for the thesis with an exploration of the research methodology and methods (chapter five).

Section two presents and discusses the findings from the different stages of the research, building an emerging picture as each is added to the preceding phase. Chapter six relates to the initial fourteen interviews, chapter seven to those with the 'autonomous' midwives, chapter eight to the personality tests and chapter nine to the accounts of critical events from the 'autonomous' midwives.

The third section explores the relationship of the theory generated to the education of midwives. It returns to the literature on learning and links the findings of this study to implications for midwifery education in the future.

Chapter Two

The History of Midwifery: Setting the Context

Introduction

> She ought not to be too fat or gross, but especially not to have thick or fleshy hands and arms, or large-bon'd wrists; which (of necessity) must occasion racking pains to the tender labouring woman...
>
> She ought to be grave and considerate, endued with resolution and presence of mind, in order to foresee and prevent accidents; sagacious and prudent in difficult cases so as not to take all upon her own shoulders and judgment, but to have immediate recourse to the ablest practiser of the art, and freely submit her thoughts to the faculty of the more learned and skillful...
>
> She ought to be patient and pleasant; soft, meek, and mild in her temper, in order to encourage and comfort the labouring woman. She should pass by and forgive her (the woman's) small failings, and peevish faults, instructing her gently when she does or says amiss: But if she will not follow advice, and necessity require, the midwife ought to reprimand and put her smartly in mind of her duty; yet always in such a manner, however, as to encourage her with the hopes of a happy and speedy delivery.

[Description of the qualifications of the female midwife by John Maubray in The Female Physician (1724) in Cutter & Viets 1964:12]

Midwifery is an occupation based on helping women through the childbirth process which has played a significant role through history. "It is generally recognised that the midwife has been with us since biblical times and that midwifery is the oldest female occupation and without doubt one of the most important" (Marland 1993). The very early description of the midwife above identified a number of key concepts which remain as significant to the role today as they were when John Maubray wrote this. The characteristics of being soft, patient, considerate and pleasant are significant to the part of the midwife's role in relating effectively to the woman. Those of sagaciousness and prudence relate to the importance of judgment and decision making in safe practice. The ability to 'submit her thoughts to the faculty of the more learned and skillful' identifies the issue that the midwife is part of a team of supporters in childbirth and needs to refer to the appropriate other team member when complications arise.

This chapter initially provides an analytic review of the history of midwifery, as an understanding of the roots of the occupation are crucial to the analysis of its contemporary status. The development of midwifery over the past number of centuries has positioned it, as an occupation, with relatively limited status and authority as compared to medicine. An understanding of the reasons why this has taken place is an important part of setting the context of contemporary practice, in which the midwives in this study operate. The chapter then moves to a discussion of issues relating to the 'profession' of midwifery and its power base as part of the team providing services to childbearing women. The hierarchical nature of the National Health Service as a bureaucracy and the power relations within the service are also discussed. Exploration of the context in which the majority of midwives currently practice is an important first step in providing a backdrop for interpreting the findings from this study.

Historical Context for Contemporary Practice

Throughout most of history, women having babies were attended by women (Arney 1982). Kirkham (1996:167) highlights that the midwife was 'part of a closely knit community' in pre-industrial European society and that 'for many centuries midwives cared for childbearing neighbours when required as part of the fabric of their domestic life'. This situation would have been similar in most parts of the world but developments in Europe from the 16th century led to significant changes which impact on the way midwives practice in the Western World today.

Midwifery in Britain - Pre Twentieth Century

Pre-Industrial Midwifery

It has been suggested, in pre-industrial society, there were three main hierarchies, that of men over women, Church over laity and landlord over peasant (Oakley 1976). The majority of midwives were women before the seventeenth century (Kirkham 1996) and so, on a gender basis alone, it could be anticipated that their status in society may have been limited. However, Hobby (1999), in introducing a manual written in 1671 by a practising midwife (Jane Sharp's 'The Midwives Book or the Whole Art of Midwifery Discovered') creates a somewhat different impression. She identifies that the midwife may have been in a unique position as, at a time when a woman was "supposedly absorbed into her husband's identity", the midwife "could earn enough to make a comfortable living in a line of work still largely closed to men" (Hobby 1999:xi).

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Midwives may have had a status, which most women were denied, by virtue of their employment in an all-female sphere where men posed no threat to their authority. Wilson (1995:26) supports this and suggests that "power, then, was a defining feature of the midwife's office" as she took charge in labour and stayed there until the birth was over, being paid in some way for her efforts. It cannot be expected that all midwives operated under the same conditions; Hobby (1999) points out that midwives in the 1600 and 1700's were as various as other medical practitioners of the time. Some will have provided care extending from the early antenatal period until well after the baby was born and received a handsome fee for the effort (Hobby 1999), whereas probably the majority would have had a more limited sphere and income. Regardless, at this point in history, midwives seem likely to have had autonomy in their practice and some status in society.

In respect of the second hierarchy (Church and laity), Hobby (1999:xi) points out that midwives "played a crucial role in the male-run church"... "participating in baptism and churching ceremonies". However, in order for the Church to exert authority over midwifery, in 1512 in England, Parliament had placed the licensure of midwives under the control of the Church (Arney 1982). Hobby (1999) confirms that it was illegal to practice midwifery without a licence granted by the Bishop (sometimes at relatively great expense). Midwives had to produce either clients who would testify to their skills before they were licensed (Donnison 1977) or testimonials from other medical practitioners or church ministers (Hobby 1999). So midwives were controlled by the Church but also contributed to its work in a way which seems likely to have afforded them some status in pre-industrial communities.

The third hierarchy (landowners and peasants) is not likely to have been one which midwives challenged, as women were generally not land owners nor were midwives part of the gentry. Although property ownership would not have afforded the midwife status, Oakley (1976) claims that midwives were trusted parts of the community. In pre industrial European society, the female healer, including the midwife, was probably more trusted than her male counterpart. She was respected for her knowledge and ability to treat conditions, she was able to earn a living at a time when women were rarely in gainful employment outside of the home and she was an active participant in important ceremonies in the Church. Therefore, in Oakley's analysis, it would seem

likely that midwives did challenge the hierarchies of the time and have autonomy (which has rarely been the case since).

A fourth hierarchy that became more evident as the pre-industrial period progressed was that of medicine over midwifery. The increased interest in knowledge and scientific approaches, which became prevalent during the Renaissance period, had a significant impact on the status of midwives and midwifery. The next four sections of this chapter will explore the impact of the hierarchies of medicine over midwifery and men over women which altered the authority and autonomy of midwives over subsequent centuries.

<u>Medicine in Childbirth</u>

One key way to identify the increasing interest in childbirth by the medical community is in considering the publication of texts or manuals about the subject through history. Hobby (1999) describes the scenario in early modern Britain; childbirth was almost entirely in the hands of women but the midwifery writing was almost entirely produced by men. She points out that the British books of the time were largely exploited from translations from the Continent, which themselves were based on ancient authors (and not attributed to the sources as was the norm at the time), primarily from the writings of Aristotle, Hippocrates and Galen (Hobby 1999). These manuals focussed largely on the qualities of a 'good' midwife, similar to that described in the introduction to this chapter and were mainly written by non midwives. One notable exception is the book referred to earlier, Jane Sharp's 'The Midwives Book of the Whole Art of Midwifery Discovered' which was written in 1671 by a midwife with thirty years experience of midwifery practice (Sharp 1671 in Hobby 1999). Sharp's contemporaries (Culpeper, Sermon, Wolveridge) were medical men, often never having had any experience of childbirth. However their gender and status, by virtue of being doctors, established their authority in the field despite having little or no practical experience. Sharp did believe that women had considerable anatomical and medical knowledge but recognised that this was not learned at university but from "long and diligent practice" and was "communicated to others of our own sex" (Sharp 1671 in Hobby 1999:xxiii). This was largely unrecognised by her contemporaries of the day, who dismissed female midwives as largely ignorant.

It is difficult to know how many midwives would have been able to access any of these writings as literacy in working class women, from which the majority of practising midwives emanated (Heagerty 1997), may have been limited. Wilson (1995) claims that the majority of midwives could in fact read in the 1600s in Britain (but that writing was a much less commonly held skill). Opportunities to acquire these medical or midwifery writings, however, may have made it difficult for midwives to use them to inform their practice. Traditionally, practising midwives' knowledge would have been communicated verbally and experientially, through being apprenticed for long periods, in order to learn their trade (Evenden 1993). This knowledge has been attributed less status than that of the written word; the erosion of the authority of midwives in childbirth was starting as medical men took command of the authoritative knowledge of the day.

The first text books written by the French (who were fairly prolific writers in that period) for midwives and about midwifery were largely inaccessible to females, as women were not able to participate in formal education at the time (Arney 1982). It was largely men, who were training to be doctors, who would be influenced by these writings and would form an understanding of childbirth which was not based on practical knowledge. Medical men had significant control over the writings about childbirth and would shape the development and spreading of midwifery knowledge from a limited experiential base. "They were medical practitioners acquainted with medical books" (Hobby 1999:xviii); midwifery was being presented formally by individuals, who may never have seen labour or birth, to fit the academic convention at the time.

As the ecclesiastically sanctioned control of midwifery was taking place in England, developments in Europe were leading to an increased interest by doctors in childbirth. Public hospitals appeared in the sixteenth century in France leading to an increase in the percentage of births which took place outside of the home and affording the opportunity for doctors to become more actively involved in what had been primarily a domestic affair previously. Donnison (1977) suggests that other important developments were also taking place in France which would have far-reaching consequences for the future of both childbirth and midwifery.

> The spirit of enquiry which the Renaissance had brought to other branches of medicine was now being directed to the processes of childbirth, as part of the new scientific study of anatomy.
>
> Donnison 1977:23

This scientific interest and investigation began to strip away the perception of birth as natural, applying a rational approach which undermined the symbolic basis of traditional midwifery (Arney 1982). Progress, in relation to an increased understanding of anatomy which could inform care for childbearing women, did not come about as a result of the work of midwives however, as women generally did not have access to the new academic or anatomical studies (Donnison 1977), as discussed earlier. The "outstanding scientific achievement of the Renaissance was the rise of anatomy as the subject basic to the practice of medicine, surgery and midwifery" (Rhodes 1995:16). The knowledge which became formalised during that period led to birth being reframed, largely without midwifery input.

Science as Authority

> The word 'science' is rooted in the Latin 'scientia' meaning knowledge. In its pure sense therefore, science does not assume the nature of reality, only that it is knowable.
>
> Rose 1997:37

The making 'knowable' of the 'reality' of childbirth escalated from the early 1500's. The well known drawing by Leonardo do Vinci of the 'fetus in utero' was followed by Vesalius' book on anatomy in 1543 which depicted human organs as a result of dissection and recording by artists (Rhodes 1995). Fallopio, a student of Vesalius, identified and defined many female anatomical features in his 'Observations on Anatomy' published in Venice in 1561; these included the Fallopian tubes, ovaries, uterus, vagina, clitoris and hymen (Rhodes 1995). An understanding of the effect of the size and shape of the pelvis on labour was first described by Aranzi in 1564. Pare described the technique of turning the fetus in the uterus (internal podalic version) to assist poor progress in labour in the mid 1500s, using the knowledge of anatomy to intervene in the birth process (Rhodes 1995).

These examples of developments through that period identify an emerging priority for knowledge of the human body. The exposure of the 'inner' workings of the female

body, which would have been largely unknown previously, led to a new understanding of 'reality'. The reality for those early anatomists was considered to be 'science' or, by their definition, truth.

> The scientific paradigm was born in the sixteenth and seventeenth centuries when Newtonian physics and Cartesian reality replaced the softer and more organic logic of a world view based on religion and an Aristotelian respect for nature. A desire to predict and control events gradually replaced a less intrusive quest for meaning and significance. This displacement of one paradigm by the other has been associated with a drive towards complex technologies, rather than ecological solutions to human needs.
>
> Oakley 1986:144

This move from religious and 'softer, more organic' explanations of the body, and therefore birth, set a scene for science as the eminent source of knowledge. Science can be defined as "observation, identification, description, experimentation, investigation and theoretical explanation of natural phenomena" (Marriner-Tomey 1989:3). Shiva (1996) points out that the rise of the 'science of nature' which took place between the fifteenth and seventeenth centuries in Europe, was a revolution led by males of western origin and which set in place a gendered hierarchy for modes of thinking. She continues by suggesting that science is projected as being objective or a universal, value-free system of knowledge which has displaced virtually all other beliefs and knowledges. The movement which started some five centuries ago has been an effective means of making science the authoritative knowledge in the western world. As midwives were largely excluded from building that knowledge base, unlike doctors who were educated and involved in the investigative and experimental scientific methods, they did not either impact on the knowledge development or maintain an equivalent status to that of doctors.

Science and Medicine

It is worth recognising, however, that knowledge and truth change all the time. In Hobby's descriptions of the pre-industrial writings on childbirth, described on page 12, she points out that there were many beliefs at that time which we now find somewhat amusing, assuming that we now know the 'real' truth (Hobby 1999). These include the thought that conception only took place if each partner had an orgasm during intercourse, that labour pains were caused by the baby's struggling to be born rather

than by uterine contraction, and that the womb and breasts were attached by special vessels which allowed the postnatal blood to travel from the womb to the breasts where it was transformed into milk. New 'scientific' breakthroughs are now daily occurrences, for example genetic sequencing or cloning, yet it is impossible to know if scientists of the future will consider the knowledge we currently believe to be true as amusing, in the light of findings we cannot even consider at this point in history. Science is thought of as 'true' and 'real', but it is bound by contemporary understandings and capabilities, and these change all of the time.

There appears to be an implicit belief, from the writings in these early times to the current notion of evidence based practice (see discussion in chapter three), that medicine is science-in-action. As science became increasingly revered as truth, medicine sought to find 'scientific' answers to the challenges posed by childbirth. The impact of this will also be further explored in the next chapter.

<u>Men in Midwifery</u>

As scientific interest in birth increased, so did the part which men played in the process. "In England, the existence of this new order of practitioners had been recognised by the early 1600s with the addition of the word 'Man-Midwife' to the English language" (Donnison 1977:23). The development of the obstetric forceps by Chamberlen, from as early as 1634 (Rhodes 1995), gave male midwives (or accoucheurs as they preferred to be known) a more positive role than that of their predecessors, the barber surgeon (Towler & Bramall 1986). "No technology will gain widespread acceptance and be the basis for reform of culture unless it is introduced into an ideologically social field" (Arney 1982:27). The forceps, then, became a symbol of socially accepted change; men were increasingly accepted as having a part to play at birth. Hobby (1999:xii) identifies that the Chamberlens' "secret midwifery forceps are seen as a proper scientific intervention into birth" and that they kept the design of these secret in order to protect both their profits and their control.

This use of the word 'scientific' equates it to technological development. Although some of the developments of the day would have been based on the increased knowledge of anatomy, this in itself did not make them 'scientific'. Using Marriner-Tomey's definition above, science is explanation rather than intervention. However,

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under the name of science, many of the developments taking place in and around childbirth were interventions intended to expedite birth to the benefit of mother and baby. Male midwives or accoucheurs were those using this technology; they would have been seen as the 'rescuers' when the attempts of the midwife were unsuccessful in supporting normal birth, in cases of complication.

The midwives' role, which would rarely have been questioned before the 17th and 18th centuries, now started to be both challenged and influenced by medical men. Bourdillon (1988) identifies that, by the mid eighteenth century, accoucheurs were the most highly paid practitioners employed by the upper classes. Therefore the male midwives had moved into the influential sphere of society and were seen as more prestigious than their female counterparts. The working classes continued to be served by the lay midwife or local handywoman (Kirkham 1996). These lay midwives practised in their local communities with little or no communication between them and, therefore, were not organised in any way to challenge the increasing control over birth which the medical men were exerting. These women did not receive any formal educational preparation for their work but, as discussed earlier, were apprenticed, often for lengthy periods (Marland 1993), into learning the skills necessary to support women through the birth process. But the value of this learning was becoming less recognised as important and considered by some as inferior to the new 'scientific' knowledge.

The Dickensian image of the gin-swilling, unkempt 'Sairey Gamp' type midwife devalued any knowledge base on which practice was established. It gave the impression that these women were unscientific and therefore unsafe, despite there now being available evidence of 'unofficial' systems of training from at least the seventeenth century in London (Evenden 1993). Even though this training existed, it would not have been based on a formal understanding of human anatomy / physiology or the potential value of 'scientific' intervention. The midwives who cared for women giving birth could have been considered as ill prepared or even dangerous by those in the developing scientific community despite the fact that, both historically and internationally, birth was normally successfully accomplished under these conditions.

The early 19th century saw significant change; no longer was just birth of interest to accoucheurs but pregnancy began to be framed as a pathological possibility and, as

such, not safe in the hands of midwives. In Britain, there were moves to try to organise lay midwives through regulation; the Obstetrical Society (an organisation of male practitioners) from 1826 tried to make a case for this with some success (Arney 1982). But possibly the most significant development was in mid century, when the Royal Colleges in Britain established examinations for male practitioners in midwifery. Donnison (1977) claims that this put the final seal on the exclusion of women from controlling midwifery as women were unable to attend university and, therefore, take these exams.

Towler & Bramall (1986) point out that Elizabeth Nihell had tried to attack the male midwife in her 'Treatise on the Art of Midwifery' as early as 1760, claiming that they used forceps unnecessarily. Nihell decried the pay differential between male and female midwives and appealed to midwives to maintain the 'naturalness' of birth. However the lack of organisation and education of lay midwives would have made this plea one which few midwives heard. Donnison (1977:177) points out that the poor and sometimes illiterate working class midwife was not "the stuff of which a successful pressure group is made".

A number of groups tried to take control of the organisation and education of midwifery in Britain through the nineteenth century; for example, Florence Nightingale set up a training school and the Female Medical Society organised a Ladies' Medical College. Both of these allowed midwives the opportunity to be formally trained in a way largely inaccessible to them previously. The Matron's Aid or Trained Midwives' Registration Society (to become known as the Midwives' Institute) was formed as a key player in the move to gaining recognition for midwifery as a respectable means of employment (Arney 1982). This group was to be instrumental in both the survival of midwifery as an occupational group and its ultimate control by medical men.

The Midwives' Institute was a group of middle- and upper-class nurses and trained midwives who sought to provide respectable employment for middle-class women (Heagerty 1997). It was instrumental in bringing about the Midwives Act of 1902, which made the training of midwives compulsory to stop the perpetuation of the attendance at birth by lay (and largely working-class) women. The social standing of this group was crucial to the outcome of their energies. They aligned themselves to the

prestigious medical community and had little in common with either the midwives or women from the working-class and were, therefore, unlikely to take into account the needs and desires of these groups. The implications of this will be further discussed in the section on 'The Profession of Midwifery'.

Midwifery in the United States (U.S.)

Several developments were taking place in the U.S. alongside the evolution of midwifery in Britain; these would lead to a very different outcome for midwives and women. It is important to consider the developments in the U.S. as doctors there have taken the lead in childbirth over the past century across all spheres, virtually eliminating midwives and midwifery for a substantial period. This would have been one possible outcome for midwifery in this country had the Midwives' Institute, or some similar group, not taken an active role in ensuring its preservation. Also the relative power of the U.S. as an international trendsetter means that approaches to birth there have impacted on the norms throughout the Western world.

Several factors impacted on the possibility of maintaining a distinct occupational group in the U.S. These included the economic importance of midwifery to medical men, the lack of upper class patronage of midwives, the increased emphasis on science (or technology) in medicine and the lack of any organisation of midwives in a large and decentralised country (Arney 1982). Indeed the word 'midwifery' was largely dropped after the American Medical Association was started in 1847 as the scientific division of 'obstetrics' was considered preferable (Arney 1982). By the time midwifery was being enshrined in statute in Britain, there was a substantial move in the U.S. to remove midwives from the system of health care altogether.

Dr. Henry Garrigues published a book in 1902 (Oakley 1989:214) which dismissed any sound basis of midwifery practice suggesting that "midwives do harm not only through their lack of obstetric knowledge, their neglect of antiseptic precautions, and their tendency to conceal undesirable features, but most of them are inveterate quacks". Barker (1998) points out that the publication of 'Prenatal Care' was a systematic attempt to introduce women to a medical interpretation of pregnancy in 1913 in the U.S. This document was distributed to well over twenty two million women by the mid-thirties and effectively led to the reconceptualising of pregnancy as medically

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problematic rather than as an 'experientially and organically demanding' social transition (Barker 1998).

This widespread dissemination of medical propaganda in the early twentieth century was an important and explicit means of leading American women to the belief that they need hospitals and technology to give birth and obstetricians to safely control that process. Davis-Floyd (1998) confirms that this belief colours women's perceptions of their own bodies and their ability to give birth normally and remains prevalent today. Rothman (1996) supports the idea that American women have been systematically stripped of power and control through the routine management of childbirth. The campaign from the early twentieth century appears to have been very effective in redressing much of American society's expectations of birth and in setting up obstetricians with ultimate authority in its control.

It is not surprising that midwifery was all but eradicated in the U.S. (Mander 2002) until a resurgence of interest by women in the past few decades led to the creation a relatively new practitioner, the 'nurse-midwife'. The 'nurse-midwife' appears to be a being more socially acceptable to the medical community. It is likely this acceptance is based on two factors: nurses have limited autonomy or authority in practice (i.e. they provide the treatment prescribed by doctors) and their training/ education is based in the biomedical approach to health and health care and they are, therefore, likely to accept intervention as routine. These nurse-midwives practice primarily in hospitals with only a few supporting women outside of the mainstream obstetric system (Davis-Floyd & Davis 1997).

However through the twentieth century, lay midwives did remain prevalent in the U.S. in very specific areas, those of deprivation, remote access or minority ethnic cultures (that is, those areas least likely to provide lucrative employment for obstetricians). There are some notable examples of innovative midwife led care initiatives led by organisations like the Maternity Center Association (Lubic 1979). In addition, lay midwives have continued to practice in specific areas like the commune in Tennessee, called 'The Farm' from which Ina May Gaskin has become very well known internationally. These examples are far from the norm, however, and are based in areas of little prestige or limited potential financial gain. There has been an increased

number of midwives who have not come from a nursing background in the past twenty years (known as the MANA -Midwives of North America, an organisation created in 1982- midwives) but there is still widespread scepticism about their legitimacy. They largely practice in free-standing birth centres or in supporting home births.

Therefore, in the U.S., midwifery has developed in a very different direction than in Europe. The intentional devaluing of traditional midwifery, through the systematic dissemination of propaganda which claims obstetrics as the only safe option of care for childbearing women, has relegated midwives into relatively powerless pockets of practice. Despite the resurgence of some interest and support for midwifery practice, it remains marginal in a medically dominated health system. Technology is considered as an essential part of safe childbirth and that technology is largely the domain of medicine. Midwives, although growing in number as a result of interest by women, are generally still considered as fringe despite their efforts to meet the requirements for indepth knowledge of the 'science of obstetrics'. This adversarial approach to birth, with midwifery opposed to obstetrics as the legitimate authority on childbirth, is less explicit in Britain but the developments in the twentieth century have meant that it exists nonetheless (Taylor 1999). This conflict, in relation to control in childbirth, is an important feature of the world of midwifery in which the initial group of midwives interviewed in this study practice and will be further explored through the rest of this chapter.

Midwifery in Britain in the Twentieth Century

Midwifery became legally recognised in Britain in 1902 with the first Midwives Act. Despite this, there continued to be a large proportion of women who were supported by midwives who had not been formally trained. "Before the First World War and, in some areas, until the mid-1930's, the majority of working-class women in Britain were attended in childbirth not by a professional but by a local woman" (Leap and Hunter 1993:1). The Midwives Act allowed for lay midwives to continue to practice as there were so few trained midwives at the time (Heagerty 1997). However, there was a time scale attached to this; by 1905, all midwives had to register as 'bona fide' or they could not call themselves midwives (Heagerty 1997). After 1910, bona fide midwives could no longer legally attend births without being under the supervision of a certified midwife or physician.

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The Central Midwives Board and Legislation

The Central Midwives Board (CMB) was established as part of the Midwives Act. Its function was to approve training programmes, define 'Rules of Practice' (which clearly identified the sphere of the midwife as normal pregnancy, birth and puerperium) and set an expectation of moral good character, which was to be demonstrated in written proof submitted by individuals considered acceptable to the Board (Heagerty 1997). It also set up Local Supervising Authorities which provided routine supervision of midwives by non-midwife, middle-class lady inspectors (Duerden 2002). The CMB initially had no midwife members, as this was not considered acceptable until 1920 and even then it was statutorily forbidden that midwives form a majority (Drury & Staples 2000), with an obstetrician as its Chair. Midwifery was legitimated through the Midwives Act but the control of midwifery practice remained largely in the hands of other groups.

The developments in midwifery within the twentieth century are a reflection of the continued battle for recognised status. There was a series of additional Midwives Acts-in 1918, 1926 and 1936- which provided stricter guidance in assuring that only qualified midwives were able to attend births; many women continued to seek unqualified midwives as they were less expensive. One of the outcomes of the fourth Act in 1936 was to lay a foundation for a significant change to the working lives of midwives. The Local Supervising Authorities in England and Wales became responsible for providing a salaried domiciliary midwifery service (Towler & Bramall 1986). For the first time, midwives supporting women in their homes received a regular income, planned off duty, annual leave and financial security (although the norm was only one day off per month at the time and the salary relatively low).

The National Health Service (NHS) Act in 1946 provided free access for all women to doctors as well as midwives; it was at this point that general practitioners began to regularly see women through pregnancy in order to get the fee available to them from the NHS. As they were not required to attend the birth in order to be paid, this role was frequently left to the midwife who may not have had the opportunity to meet the woman through the pregnancy. Continuity of support suffered as a result of these changes (Towler & Bramall 1986); total responsibility by the midwife for the pregnancy, birth and postnatal period was also affected.

Changes took place in the CMB through the century; the numbers of members increased but the proportion of midwives continued to be in the minority. The most significant change took place in 1973 when, for the first time, the Chair of the CMB was a midwife. This was short lived, however, as the Nurses, Midwives and Health Visitors Act (1979) ended the CMB, moving the locus of control of midwifery from doctors to nurses. A Statutory Midwifery Committee within the UKCC was established, with some effect, following pressure from midwives (Thomas 2002) to ensure midwifery regulatory issues were not subsumed within the broader nursing agenda. This remained a vexatious point for midwives throughout the life of the UKCC as the Midwifery Committee was not autonomous and its work was controlled by Council which had a majority of nurses. There is little confidence that the new Nursing and Midwifery Council, which is being established as this thesis is being written, will provide any more ultimate responsibility for midwifery by midwives in relation to regulation and public protection.

Supervision

Supervision of midwives altered through the century as well. Following the initial introduction of supervision by non-midwives (the middle-class lady inspectors), in 1936, two types of supervisors were recognised- medical and non-medical. The non-medical supervisors were expected to be senior, experienced domiciliary midwives but they were responsible to the medical supervisors, maintaining legitimate control by the medical establishment. In 1974, with the reorganisation of the NHS, the Regional Health Authorities became responsible for midwives, delegating the Local Supervising Authority (LSA) function to District Health Authorities. In 1977, it was agreed for the first time that supervisors must be midwives (Towler & Bramall 1986) and the words 'non-medical' were removed from the title of 'supervisor of midwives' (Drury & Staples 2000). It was very unlikely, however, that these midwife supervisors would be responsible to midwives in the District Health Authority; therefore ultimate control of midwifery practice was still not in the hands of midwives.

There has been a tension within the role of Supervisor since the early days of the twentieth century when they were known as Inspectors and their function was to investigate cases of misconduct, negligence and malpractice. Despite the 'Ministry of

Health Letter' in 1937 stating that the newly titled 'supervisor' should be 'regarded as a counsellor and friend to midwives rather than as a relentless critic' (Drury & Staples 2000:160), the role remained largely a 'policing' one (Halksworth, Bale & James 2000), with little evidence of close support for the midwives being supervised. Possibly the most significant change in the quality of supervision was brought about in 1993 when it became a requirement that new supervisors undertake an educational programme of preparation for the role (Mayes 2000). Following this development, from 1996 for the first time, all Local Supervising Authority Responsible Officer posts were taken by midwives (Duerden 2000). These two developments have ensured that supervision is now in the hands of midwives and that there is a consistent understanding of the remit of and positive potential of the role. However, the LSA responsible officers are accountable to the National Health Service Executive regional offices for exercising their statutory functions and often relate to the regional directors of nursing as the main point of contact (Duerden 2000). Despite the authority levels of midwives increasing (there now being two tiers above the practising midwife which must be midwives- the supervisor and the LSA responsible officer), there still remain other groups in ultimate control of midwifery practice via the supervisory route.

The effectiveness of the supervision function as a support to midwives, rather than as a policing role, was explored in a study reported in 1998 (Stapleton, Duerden & Kirkham 1998). The key results of this study demonstrated variable quality of supervision, some supervisors being perceived as helpful and supportive and others as intimidating and undermining. Power was an important theme in this study; the supervisor was perceived as relatively powerful especially if the supervision role was alongside a management one. The vast majority of midwives supported supervision, however, and wanted to see the model of support continue as they felt it had a direct impact on their professional well being and the service they were able to give to clients. Therefore, it would seem that supervision does offer support for many midwives but, in cases, it can be controlling and disempowering. Some midwives appear to be constrained rather than enabled through this mechanism of professional support.

<u>Patterns of Care</u>

The changing patterns of maternity care over the twentieth century have provided another challenge for midwives. Increasing rates of hospital births supported by successive government reports (Cranbook Report 1956 recommended 70% hospital birth, Peel Report 1970 recommended 100% hospital birth), the technologies and interventions which became much more common place in the late 1960's and early 1970's (induction, use of Syntocinon for augmentation, electronic fetal heart rate monitoring, episiotomies) and the increased proportion of obstetricians employed within maternity services, all impacted on the autonomy of the midwives' role (Towler & Bramall 1986). The increasingly technological approach to birth has largely followed the pattern of change in the U.S. where intervention in birth became the norm in advance of it happening in Britain.

In the 1980's there was a continued emphasis on hospital birth supported by the Short Report in 1980 but, as a result of criticism by women of the impersonal service this provided, there was a move to make hospitals a nicer place in which to give birth. The change in the 1990's instigated by Changing Childbirth (DOH 1993) was probably the most significant in the century in terms of the midwives role. It promoted midwives as the ideal supporter in cases of normal childbirth and identified the importance of women being able to have choice, continuity and control of their experience (to be discussed further in the sections 'Effects of Professionalisation' in this chapter and 'Choice, Continuity and Control' in chapter three). Despite this report being an ideal tool for midwives to use in increasing their autonomy, the current politics and power struggles in maternity services continue to make this difficult to achieve. The continued dominance of childbirth by medicine places midwifery in a lesser position of authority and power.

Summary of History

Midwifery has survived in Britain and has started to be revived in the U.S. It would seem that it is still recognised as an important occupation, valued by women. However its history has been one of conflict; despite pre-industrial midwives being in positions of relative authority, changes over subsequent centuries have eroded this authority. The rise of science as authoritative knowledge, the involvement of men and the influence of medicine on childbirth have all had impact on the status of midwifery and the control of

midwives. In the past two centuries, other occupational groups have been vying for control over the midwifery sphere of practice. The current position still places midwifery in a subordinate position in terms of regulation, supervision and childbirth practice despite significant improvement in its sphere of authority. The next section of this chapter will explore issues of professions and power, that are significant to the position of midwifery in contemporary Britain and which help to further explain its current context.

The Profession of Midwifery

Options for Midwifery in 1902

> The Midwives' Act of 1902 constituted a radical break with midwifery's past. At that time midwifery was unorganised, typically practised by working-class lay midwives, and was an integral part of the network of economic and social relationships which comprised working-class life and culture. The Act provided the legal power to reform the practice of midwifery, to alter the relationship between the midwife and the mother (and thereby the midwives' relationship to the working-class community), and to create and sustain a powerful apparatus of enforcement.
>
> Heagerty 1997:70

Anne Witz (1992) suggests that, when midwifery was first regulated in Britain by the Midwives Act of 1902, there were three options available: midwifery as autonomous with status similar to medical men (considered to be too challenging to be possible), its dissolution into obstetric nursing (as was the case in the U.S.) or its strict control in terms of sphere of practice (i.e. 'normal' childbirth). In order to prevent all of midwifery practice being under the direct supervision of a doctor (as would be the case in the second option), it was agreed by the politically active midwives (and their supporters) at the time that the latter would be preferable. This 'demarcationary strategy of deskilling' (Witz 1992:116) clearly identified a sphere of competence that limited the potential control of midwives. They were relegated to a sphere that was considered to be less important than that of medicine because it related to the female role of caring rather than the male one of curing.

Caring versus Curing

Prestige is associated with work "requiring highly trained and skillful practitioners and is directed towards curing and problem solving" (Hugman 1991:99). Control over diagnosis is perceived as a very significant element of authority (Porter 1991); the

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specialised knowledge required to diagnose and treat, which is recognised as scientific in contemporary Western society, is the basis of this authority (Hagall 1989). The gendered role of caring, tending and long term support has lower status; by defining midwifery as a caring function, there was little threat to medical dominance and was therefore an acceptable option for legislation. Effectively midwives surrendered autonomy to doctors in exchange for registration in 1902 (Clarke 1993). Midwives, then and now, had and have no authority to challenge medical control of childbirth when a complication arises (although they will be deemed to have a responsibility in cases when decisions have been made which lead to a poor outcome).

Place of Birth

While 'normal' birth most commonly took place in the home (in Britain this was largely the case until the 1960's), this demarcation was relatively easy to maintain. Midwives practised in the home; if the woman was required to come to hospital due to complication the medical specialist took charge. There was a half way scenario; nursing homes / cottage maternity units and general practitioner units were options for women who chose not to give birth at home but were not unwell in the pregnancy. These have virtually disappeared although birth centres are now increasingly becoming popular alternatives with a similar role to the nursing home. The distinction between the midwife's role and that of the general practitioner was somewhat less clear as both provided mainly primary care in the community, although obstetrically-trained GPs would come to home births for complications in labour or at birth. But the role of the midwife and specialist medical practitioner (for example, obstetrician, paediatrician and anaesthetist) had reasonably clear differences.

This position changed in the 1960's and 70's when there was a shift from home birth being the norm (Harcombe 1999). Allison (1996), in describing the work of district midwives in the years between the creation of the National Health Service (1948) and its first major reorganisation (1973), creates an image of midwives who truly did practice autonomously when supporting the majority of women through birth at home. The NHS Reorganisation Act, which came into force in 1974, led to a change of employer for midwives and integration of community and hospital maternity services. District midwives were no longer employed by the Local Authority (local government) but by the Health Authority (as are doctors, nurses and allied health professionals) and

were subjected to the nursing hierarchies and relationships which existed in hospitals. This allowed for increased control over midwives by obstetricians who became increasingly involved in normal pregnancy and birth through mere access to it.

Birth as a Medical Event

As raised earlier in this chapter and will be further discussed in chapter three, alongside the increased blurring of the midwifery role came the increased blurring of the social event of giving birth. The redefinition of pregnancy and birth as experiences requiring medical intervention provided opportunities for increased control over the childbearing woman and her experience. "From the Foucauldian perspective, power as it operates in the medical encounter is a disciplinary power that provides guidelines about how patients should understand, regulate and experience their bodies" (Lupton 1997:99). Indeed, patients who do not follow these guidelines become labelled as non-compliant and their mental health may be called into question if they choose not to 'follow doctor's orders' (Playle & Keeley 1998). The change of venue for birth provided the opportunity for doctors to draw up guidelines or protocols for the expected course of birth (which will be explored further under 'risk management' in chapter three) and led to women being redefined as patients (as the occupants of hospitals are virtually always known) with its connotation of illness. The guidelines or frames of reference around birth subtly changed and the regulation of the event became more externally controlled and explicit.

Definitions of a Profession

As discussed previously, the struggle to achieve professional status for midwives in Britain lasted more than a century. This struggle has ended in a position where midwives, by being defined as professionals, have been somewhat removed from the women they serve as they are no longer part of the same social group (Kirkham 1996). However, despite professionalisation, midwives are still significantly controlled in the traditional maternity services in this country. Some refer to midwifery as a semi-profession, similar to other predominantly female occupations like nursing and teaching. Semi-professions or 'lesser' professions (Bond & Bond 1986) include some of the characteristics of professions, to be explored further below, but lack ultimate control of their practice. This would seem to be in keeping with the current position of

midwifery in Britain. The question arises as to whether either professional or semi-professional statuses are desirable outcomes?

Friedson (1983) claims that one view of professions is as "honoured servants of public need, conceiving them as occupations especially distinguished from others by their orientation to serving the needs of the public through the schooled application of their unusually esoteric knowledge and complex skill" (p19). This definition can be broken down into four main issues (Blane 1991). Firstly, the professions represent a highly skilled sector of the labour market with a defined body of specialised knowledge. This knowledge is transmitted to trainees who are prepared in institutions under the control of the profession; the knowledge base is extended through research. Secondly, there is a monopoly on the field of work in that practitioners must be registered by the state as being suitable to practice the profession and there is agreement by substantial employers that only those registered will be given a job. Thirdly, there is autonomy in the organisation, development and definition of the nature of the work undertaken. This implies that only a member of the profession is competent to assess another professional's work. Fourthly, there is a code of ethics which prohibits the exploitation of clients and regulates intra-professional relations.

Is Midwifery a Profession?

If these criteria are applied to midwifery, it is clear that the majority are fulfilled by the occupation as it has evolved in the West in this century, although as highlighted earlier, some might define it as a semi-profession. Midwives are highly skilled with a body of specialised knowledge which is taught to learners and extended by research and includes an explicit ethical code (ICM 1994). Registration is required in order to practice legally in Britain; employers regularly check that midwives are registered with the regulatory body when employing them. The assessment of competence is now largely undertaken by other midwives at both pre-registration and post-registration levels.

However, the control by midwives of education, training and professional issues are fairly recent developments in the U.K., as it has only been since the 1980's that obstetricians have no longer played key roles in these aspects. As discussed earlier, there was a predominance of obstetricians on the Central Midwives Board, the

regulating organisation for midwifery which was replaced by the U.K.C.C. in 1980. Obstetricians were fundamental in the training of midwives until that time, as there was a requirement that each student midwife have ten lectures by an obstetrician in her training. In addition, obstetricians were involved in examining midwives' competence at the end of training in order to certify them fit to practice. Although obstetricians are no longer regularly or statutorily involved in midwifery education, it could be argued, however, that obstetric / medical approaches have become so institutionalised that these formal links are not necessary to perpetuate medicalised practice.

Nevertheless, the two past decades have seen considerable reduction in the formal control by obstetricians in the education and practice of midwives in the U.K., opening opportunities for more self determination and autonomy in the profession (although there has remained some conflict with midwives being regulated alongside nurses and health visitors). Although far from being completely autonomous in practice, legislation in Britain does define midwives as 'practitioners in their own right' which does suggest a substantial degree of control. It could be argued that this control is dissipated by the regulatory body including nursing and by the institutionalised medical approach to birth. However, possibly more importantly, the desirability of this control and its potential for abuse of power needs to be explored in relationship to the desirability of being a 'profession'.

Effects of Professionalisation

The debate around the notion of professionalisation is well established in sociological circles. Haralambos & Holborn (1991) suggest that the growth of the professions in the 20th century is based in the increased specialised knowledge demands which are generated from scientific and technological developments. In relation to the health and social services, the creation of the welfare state has resulted in large numbers of people being employed in occupations which have increasingly created divisions of knowledge and practice in order to effectively cater for the needs of the population. Although this separation of function and purpose may seem an appropriate means to meet client needs, criticisms arise from the effect this professionalisation of occupation has on individuals.

<u>Disabling Effects</u>

Caplan (1977) cites three specific disabling effects which arise from professionalised assumptions of need. "Professional practice consistently defines a need as an unfortunate absence or emptiness in another" (Caplan 1977:78). The concept of need from this perspective is as a deficiency, placing the professional in the position of being the only one able to correct it. This need is placed in the individual rather than in the society as that is the only means by which the professional can deal with it. Individuals who are deficient seek a remedy from the professional who is specifically trained to deal with that aspect. This in turn indicates the specialisation of need, which is created through the availability of expertise to deal with it. People visit a variety of medical and other specialists to deal with different parts of their anatomy (e.g. gynaecologist, podiatrist, neurologist), different stages of their lives (e.g. paediatrician, geriatrician) and different aspects of their psyche (e.g. psychologist, psychiatrist, priest). To sum up, "professionalised services define need as a deficiency and at the same time individualise and compartmentalise the deficient components... people are a set of pieces in need, both in time and space" (Caplan 1977:82).

In addition to these disabling effects of professionalisation, which result in a dependence on the skills of others, there is a reduction of the common area of shared experience and knowledge and an increase in social distance (Johnson 1972). The Weberian perspective on professions (Haralambos & Holborn 1991) sees these regulated occupational groups as controlling and manipulating the labour market in a way so as to maximise their rewards. Because the common understanding between client and professional has been reduced through the development of specialised knowledge, there is freedom to manipulate or 'blind them with science'. We can probably all think of situations in which we are at the mercy of the integrity of the practitioner to whom we are relating as we have very little comprehension of the world in which he or she practises. "Professionals assert secret knowledge about human nature, knowledge which only they have the right to dispense. They claim a monopoly over the definition of deviance and the remedies needed" (Illich 1977:19). The power set up in this relationship is in favour of the professional not the client. How then does midwifery fit into the concept of a profession if it is to maintain its very definition, that is to be 'with woman' (not above)?

Power and Control

Power and control can be considered as positive or negative concepts. Midwives have sought control over their occupation, the self determination associated with professionalisation. This is seen as a positive as the status of a self determining group is recognised and respected by the community at large, as is the case with medicine. However this control, to be true to the values of a practitioner whose role is to support women giving birth, should be used to enable and empower women to achieve their expectations of the childbirth experience. This use of power is not always the case in contemporary practice, however, as a number of issues interfere with the positive use of control.

Gender Issues

The phrase 'practitioner in your own right' is one commonly used by midwives to suggest that they are professional and autonomous. Symon (1996) indicates that a tension is created between the ideal concept of the professional and the characteristics accorded value in midwifery. The supposed male features of being detached, objective and distracted which are frequently considered to relate to professional stance (Davies 1995) appear to be in direct opposition to the more female qualities of empathy, direct contact and communication which are associated with midwifery practice. The 'artistic' elements of midwifery which focus on interpersonal skills and caring seem an unlikely fit in a professional model of behaviour which regulates, manipulates and controls the client group. "Some argue that the very notion of a profession is gendered and question whether the medical model of a profession is an appropriate one for midwives to follow" (Symon 1996:545).

> The traditional male emphasis has been on objectifying experiences and so 'getting away from' the personal into some transcendental realm of 'knowledge and truth'. For feminists, the key consequence of this is that it denies validity to women's understandings of women's experiences because these are merely subjective, rooted in the particular. It also, of course, denies validity to the realms of emotion and physicality more generally, instead arguing that 'rationality' and 'mind' are superior to these.
>
> Stanley & Wise 2002:63

This objectivity, associated with science (as discussed earlier) and with male perspectives on reality, is the basis of patriarchy or the prevailing norm in the gendered organisation of the contemporary National Health Service. "Whether power in an organisation is determined by role, position, person or task, it is always gendered; and however it is exercised, the power in organisations is male" (Itzin 1995). Power provides a platform for achieving the intended goal; if power is used to support the individual needs of the woman by helping her to achieve her goals, it can be construed as positive. However, DeVries (1993:130) proposes that the "history of midwifery demonstrates that medical systems are not rational and predictable applications of science, but are instead social products subject to the influence of structural arrangements and cultural ideas". Rather than medicine being the application of the objective reality of science (as discussed on page 16), it is a powerful force which often perpetuates the legitimate authority of doctors as a priority rather than effectively supporting the needs of those seeking care.

The theory of the corrupting effects of power proposed by Kipnis et al (1977) indicates that power may provide a very negative influence on the professional / client relationship. These effects start with the possession of power leading to its use, moving to a change in status between the powerful and powerless creating social distance and ending with increased self esteem in the power holder and personal devaluing of the power less.

Negative Effects of Power

The potential for this negative effect of power is very real in midwifery practice; many midwives do use the power available to them to try to control the woman's experience and not always in ways which women see as supportive (Mason 2000). Many authors are suggesting that midwifery needs to be underpinned by feminist values, moving away from the hierarchical male organisational structures and relationship power differentials (Hanna 2000, Kent 2000, Barnes 1999, Stephens 1999, Davies 1999, McLoughlin 1997). But it would seem that this is still not the common approach prevalent in British maternity services despite the rhetoric of 'choice, continuity and control' (D.O.H. 1993 - see sections on Continuity, Choice and Control in chapter three) being a driving force for the past decade. It raises questions as to why midwives are not changing the systems they work within and the way they relate to women.

It may be that the dominance over women is a compensatory factor for midwives who are dissatisfied with the status attached to their chosen profession, a status which has been established through dominance by other professional groups through history (as discussed previously on pages 23 to 27). Midwives may feel devalued by other professional groups (especially medical ones) and therefore transmit the frustration they feel over the lack of autonomy they experience in their occupation onto the women they deal with. Bond & Bond (1986) point out that health care teams remain medically dominated as a result of the socialisation of 'lesser' professional groups (often referred to as semi-professions). As highlighted earlier, semi-professions are said to be occupations which combine the revered technical, scientific-type knowledge requirement with experiential, interpersonal skills (Burkitt et al 2001). These groups are taught to defer to the gender, social class and knowledge 'superiority' of medical practitioners from the beginning of their professional education even though this aspect is not made explicit. The observation of qualified members of the group by students instils a strong set of values and 'special treatment' of the doctors is still seen fairly frequently in hospitals today. This 'learned passivity' (Itzin 1995) is passed onto students via the role modelling they witness in their mentors in practice (to be discussed in chapter four). Students also often learn to play 'male / female games' and to manipulate the situation in order to get what they feel is right rather than confronting and changing it (Littlewood 1991). The scene is set for dominance and a hierarchy of power. The midwife is controlled by many - doctors, Supervisors of midwives, managers (Davies 1988). In terms of status, the midwife sits below all of the levels of medical practitioners, the woman further down still.

Bullying / Horizontal Violence

Kirkham (1999) points out that the behaviour of midwives in Britain emulates that of an oppressed group, with low self esteem and unsupportive behaviour to colleagues. As the more powerful profession of medicine has defined the sphere of modern midwifery (Heagerty 1996), Stapleton et al (1998) suggest that midwifery fits the definition provided by Roberts (1983) of an oppressed group as "one which is controlled by societal forces that have determined its leadership behaviour". Stapleton et al (1998) carry on to point out that Freire's (1972) analysis "gives us insight into how, in the process of internalising the values of the more powerful group, the original

characteristics of the oppressed group come to be negatively valued" (p22). This lack of value leads to reduced self esteem in the oppressed group and can cause destructive behaviour within the group. The lack of relative power can result in bullying tactics within the group, especially when a member has moved somewhat up the ladder of power (for example, a higher grade of midwife or ward manager). "It is a rare peasant who, once 'promoted' to overseer, does not become more of a tyrant towards his former comrades than the owner himself" (Freire 1972:23).

This non-supportive behaviour can be referred to as horizontal violence, a manner in which "oppressed groups direct their frustrations and dissatisfactions towards each other as a response to a system that has excluded them from power" (Leap 1997:689). A Royal College of Midwives' survey on bullying in midwifery found that 43% of midwives said that they are bullied at work; of those, 51% by a more senior colleague, 41% by a midwifery manager, 21% by a Supervisor of midwives, 12% by a midwife on the same grade and 10% by medical colleagues (9% hospital medical staff and 1% general practitioners) (RCM 1996). These findings seem somewhat surprising; assuming the 'more senior colleagues' are midwives, there would appear to be a lack of mutual support available within the midwifery community. Bullying does not appear to be coming mainly from medical colleagues, as might be expected in the gendered hierarchy described previously. It appears to be happening from midwife to midwife, presumably as an expression of the frustration which Leap (1997) describes. What the survey does not tell us is how many women suffer as a result of the oppression experienced by midwives. If such a substantial number are inappropriately lashing out at colleagues, it seems likely that women may also experience bullying, due to midwifery occupational frustration.

Robinson (2000) claims that there has been a substantial increase in the number of complaints currently being received by the Association for Improvements in the Maternity Services about 'nasty' midwives. It is difficult to know whether this 'nastiness' has in fact increased or whether women have only started reporting it recently. However, the stress caused by bullying in the workplace from professional to professional and from professional to client appears to be an increasing phenomenon in maternity services (Hadkin 2001).

Potential Positive Use of Power

Foucault's analysis of power (1991) suggests that power produces reality, with domains of objects and rituals of truth; power creates its own culture which can be positive and supportive in the right conditions. Foucault's analysis suggests that the potential of power provides the opportunity to create a culture which could be to the benefit of women, reminiscent of the pre-industrial midwife who was able to largely self determine as a result of lack of interest by other professional groups. However the increasing numbers of complaints about the behaviour of midwives would suggest that this power is not regularly being used positively, to the benefit of women. The perceived lack of status of midwifery in the bureaucracy of a National Health Service (to be further discussed on page 40), dominated by medicine, seems to have interfered with midwives being able to consistently provide positive support. The strength of the partnership between women and midwives is largely unexploited in the current provision of care, as will be identified through the initial interviews undertaken in this study and discussed in chapter six. The positive use of power is much more strongly associated in this study in the second group of midwives interviewed and this group has largely removed themselves from the mainstream health service to ensure they are able to provide positive support without interference.

Power can be a positive force, but in the more recent history of midwifery, it has been used frequently in a disciplinary manner to repress and exclude. It would seem possible that the 'horizontal violence' present (and possibly increasing) in midwifery and within midwives demonstrates a frustration within the groups which is being channelled, by some, into the discipline and punishment of women. This may be as a result of feeling inferior and subordinate to the revered medical profession. "If power corrupts so much more does powerlessness. It corrupts by changing our perceptions of ourselves... being too subordinate, too alienated or too weak to affect change" (Sheahan cited in Harcombe 1999:81).

Many midwives seem to be in relatively powerless positions; the power available to them may not be always used to women's best advantage as a result of frustration, overwork and low self esteem. The next section will look at the bureaucratic nature of

the British health service and considers the impact this has on grass roots
practitioners, including midwives.

Bureaucracy in Practice: Its Effects of Midwifery
Street Level Bureaucracies

Lipsky (1980) describes those working in the public sector, providing services to the
community in large organisations (for example teachers, policemen, lawyers, doctors,
nurses, midwives), as 'street-level bureaucrats'. In a consideration of the working lives
of midwives in Britain, this is a very helpful analysis as the National Health Service is
one of the largest bureaucracies in the country. Lipsky (1980) points out that public
service workers represent the government to citizens, they make decisions about
people which will affect their lives and therefore are in powerful positions in some
respects (they control individual outcomes on the basis of interpreting policy into
practice). There are rules within which street-level bureaucrats function but they
exercise discretion in the decisions they make within these rules. Complicated
individual situations and the human dimension mean that the rules need to be
interpreted in each scenario, requiring the street-level bureaucrat to make decisions
within a broad framework (Lipsky 1980).

Conditions in a Bureaucracy

Lipsky (1980) identifies that the conditions in which street-level bureaucrats work,
however, impact on the decisions they are able to make. Resources are chronically
inadequate in the public sector with the demand for services generally outweighing
supply. The goals of the organisation for which they work tend to be ambiguous or
vague therefore working towards achieving those goals may be difficult if not
impossible. In street-level bureaucracies, clients are not usually there by choice; they
are an involuntary group who need the services and are not easily able to choose to
not be involved, regardless of the quality of service they receive. This is reflective of
the discussion about the effects of professionalisation (pages 32 and 33); citizens need
the services of street-level bureaucrats who are likely to be professionals or semi-
professionals. The professionals hold the key to solutions to which individuals
otherwise would not be afforded access; they are gate keepers to a body of
specialised knowledge and understanding which eludes the average citizen.

Therefore street-level bureaucrats are in positions of relative power in relation to the clients but are working in systems which do not effectively support that power (that is, they themselves are relatively powerless in a large system). The impact of resource limitation on the street-level bureaucrat is that they often carry large caseloads, have limited time to dedicate to each client or situation and may suffer from inadequate or underdeveloped personal resources due to under investment. Lipsky (1980) suggests that, in relation to health care, the population will always absorb what is on offer and demand more. This places an added burden on street-level bureaucrats who may feel frustrated by their inability to meet demand.

Coping in a Bureaucracy

Street-level bureaucrats need coping mechanisms to deal with the inherent tensions in their roles (Lipsky 1980). They see themselves as working under great strain, needing to make sacrifices in order to fulfil the role and believe that they are undertaking a role which few others would ever want. Some of the coping mechanisms implemented include the routinisation of practice, using patterns which do not allow clients to place too heavy a demand, the modification of one's own objectives so that they match the available resource envelope and the modification of client expectation so any accomplishments are seen as meeting an acceptable level. The control of clients, in addition to modifying expectations, is extended by controlling the environment of encounter, invoking sanctions for non-compliant clients, controlling the pace, content and timing of interactions and intimating that the bureaucrat knows what is best for the client.

Maternity Services as Street Level Bureaucracies

In respect of the NHS (in general) and the maternity services (in particular) as street-level bureaucracies and midwives as street-level bureaucrats, Lipsky's analysis would appear to have much synergy. Midwives who work in the NHS function within a system of rules, both nationally dictated and locally defined as protocols or guidelines (to be further discussed in chapter three). They must interpret these rules in individual cases with considerable discretion but also under considerable scrutiny from others in the service. Resources are limited within the NHS; these include both physical resources and human ones with the numbers of midwives chronically depleted in many maternity units currently. Therefore midwives are often expected to carry larger than ideal

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caseloads; this impacts on their ability to provide a satisfying service. They see themselves as working under great strain and making many sacrifices in order to deliver an acceptable standard of care. Women are controlled through a variety of means to bring together the objectives and outcomes of service delivery.

Midwives who work in the NHS are in positions of tension, trying to meet the needs of the organisation as well as the needs of the women within a constrained resource envelope. They may start their professional careers with ideals of practice which become limited by the care they are able to realistically offer in pressurised services; they may modify their objectives to meet the resources available. They also may try to modify the expectations of the women as to what the service can realistically offer, to reduce the likelihood that they will not be able to meet the woman's expectations. This is a particularly relevant point in this study, as will be explored in chapter six.

On a more personal level, the street-level bureaucrat's relative power over individuals relates back to the pre-industrial midwife's position. As described on page 12, midwives in that period operated in a sphere largely unregulated by external forces; their practice was both individual and personal with childbearing women, not in the public sphere nor under public gaze. The changes over subsequent centuries, when midwifery increasingly became part of a bureaucratic service delivery, changed the individual midwife's perception of relative autonomy and authority. 'A small cog in a big wheel' is how many midwives today would define their positions.

However, the individual control which a midwife has today, in relation to care and support offered to women on a one-to-one basis, is as real now as it was in the 16th century. Midwives make a significant impact on the perception of the pregnancy and birth experience by individual women (to be discussed in the section on relationship in chapter three) and there is substantial evidence that the midwife's attitude is key to a positive experience (for example Hutton 1994, Fleming 1998, Wilkins 200, Anderson 2000). Midwives indeed are in a powerful position at a micro level, being able to interpret policy, guidelines and protocols in a way which will meet the needs and wishes of individual women.

As members of a large bureaucracy, this power may be largely unrecognised, or at times abused, by midwives practising in the NHS. Midwives may not really be able to see the effect they can have on women in a fragmented system where they only provide care for a defined episode in the childbirth experience (to be discussed further in the section on continuity of carer in chapter three). A midwife who only meets the woman at one antenatal visit or during part of her labour is not likely to understand the priorities for that woman and may deal with the situation in a routine way, not sensitive to individual needs. As the midwife might then never see that woman again, there may be no feedback about the suitability of her / his approach unless it comes in the form of a complaint. In addition, if the midwife feels constrained in her own decision making as a result of scrutiny by others in the service (Trust managers, regulating body, other professional groups, more senior midwives, Supervisors), she / he may display that frustration in the approach used with women. The relative power of the midwife as street-level bureaucrat may not always be used positively or productively.

This analysis is a useful one, which brings together the historical development of midwifery, the issues of professionalisation, gender, power and control with the bureaucratic context of a large public service organisation like the NHS. It helps to explain some of the stresses and reality of contemporary midwifery practice in the U.K., the conditions in which the initial group of midwives interviewed in this project are working.

Summary
Crooke (1991) places a challenge for midwives by suggesting that the public needs to re-establish its confidence in midwives and their practice (as was the case in pre-industrial society), not seeing midwifery care as secondary to obstetric care. The history of midwifery has shown that this is not a new issue; midwives have struggled over the past centuries to have their role valued in a world that has increasingly placed importance on science and technology more than on interpersonal, social relationships. The control by other professional groups through the last century and the current context of the health service provide an important understanding of the position of midwifery and midwives; this context will be important in the interpretation of the findings from this study.

The next chapter presents a structured review of the concepts currently being discussed and debated in the midwifery literature. Many reflect and build on those raised in this chapter and the issues discussed in both chapters identify current priorities in midwifery practice (some of the 'what' that students of midwifery need to learn).

Chapter Three
Concepts in Midwifery:
What Does the Literature Say is Important?

Rationale for Literature Review

The first step which I undertook, at the beginning of this project, was to do a structured review of the midwifery literature to determine what the conceptual basis of my educational strategy should be. As was raised in chapter one, there was discussion in the literature about the lack of explicit midwifery theory, with agreement that the theoretical concepts used to frame the profession have largely been 'borrowed' from other disciplines. This review confirmed that there are substantial gaps in the conceptual framework for midwifery; many important concepts are being considered by contemporary writers but these do not appear to cover the whole scope of midwifery practice.

This chapter will start with an exploration of the role of theory and concepts in providing a framework for practice. The work of some current midwifery theorists will be examined to determine the scope and significance of theory development to date. Having identified the value of articulating theoretical bases, the structured review of current literature will then be presented, identifying the priorities for writers in and about midwifery. These priorities are grouped as concepts, the building blocks of theory. The chapter will culminate in a discussion about the integration of these concepts with an attempt to identify gaps in the current midwifery theoretical framework which would benefit from further consideration and research.

The Role of Theory

Theory is implicit in the practice of any occupation; in order to practice effectively, all practitioners must have some level of knowledge base and be able to use it. The operationalisation of this knowledge will be underpinned by a theoretical framework but often this base is implicit and embedded in the practitioner rather than being something tangible and obvious. The theoretical framework may be interpreted through the actions taken by those in the field; students may learn the 'how' without ever really understanding the 'why' as their mentors may be unable to articulate clearly the basis for practice.

With the advent of evidence based practice, research is seen as an increasingly important type of evidence and, where there is good quality research available, this is helpful. However, as will be discussed later in this chapter, there are many aspects of care and practice which have never been researched formally yet care goes on being delivered. The evidence being used in these instances comes from a variety of other sources. I suggest that the theoretical framework is one such source as it will determine the values, beliefs and philosophical stance of the practitioner and will underpin all of their actions. However, many practitioners do not really analyse their own practice or consider in any depth the knowledge which is embedded and which influences the way they provide care and make decisions.

This embedded knowledge is referred to by authors using a variety of terminologies - to Polanyi (1967) it is called 'tacit knowledge', to Eraut (1985) it is 'semi-conscious' or 'intuitive' knowledge, to Benner (1984) it is 'expert' knowledge. Schon (1987) suggests that it is necessary to reflect on practice in order to try to make explicit the knowledge used so that the practitioner can grow and develop. Usher & Bryant (1987) postulate that examining practice through theory is a relationship between the two concepts which is interactive and mutually enriching leading to improved practice. As was suggested earlier, there is little research on the theoretical base of midwifery despite the profession being older than recorded history. It seems obvious that there is a theoretical base to midwifery practice but what is that base and is it useful to try and articulate it?

Defining and Exploring Theory

Fawcett & Downs 1992:1 provide this definition: "A theory is a statement that purports to account for or characterise some phenomenon". This definition includes several issues; a theory 'purports' to account for something, that is, it conveys or professes a meaning. This suggests that interpretation is an important element; the theory will be bound by the understanding of the individual defining it. This would, therefore, seem to allude to a personal stance; the scope and perspective of the theory will be determined by the person defining it. In addition, this definition includes the issue of characterisation, which intimates the unique or distinctive element of the phenomenon. Theory would therefore seem to be an attempt to describe something which is not

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concrete or necessarily obvious. It differs from fact in that interpretation is necessary, whereas fact is normally considered to be irrefutable or not open to interpretation.

There are many ways in which the word theory is used which are especially important when trying to determine what midwifery theory is or could be. The term theory is commonly used in nursing and midwifery as the facts or knowledge which one is taught or learns, as part of becoming a professional. Fraser et al (1997) identified in the 'Effectiveness in Midwifery Education' study that theory equated to information and facts in the midwifery curricula they reviewed; theory acquisition was based on the "transmission of knowledge as facts and information which are then concurrently used to varying degrees in the context of midwifery practice" (p33). Educationalists and practitioners alike talk of theory as being that which is covered in the classroom and practice as that which is experienced beside the childbearing woman. The theory / practice gap, which is so often discussed as being problematic for students and will be discussed in chapter four, highlights this understanding of theory - the facts, likely course and ideal outcomes which are presented in the classroom often do not match the realities experienced once in the clinical environment. This superficial use of the word theory has possibly impaired the development of a suitable conceptual framework for midwifery as practitioners may believe that they have a theoretical base because they learned 'theory' in their training. If Fawcett and Downs' definition of theory is applied to midwifery, however, I believe that the majority of practising midwives do not operate professionally with a clear understanding of the phenomenon nor its characteristics.

Theory in Nursing

Nursing has grappled with the idea of theory for some time, as its unique contribution to knowledge has often been left implicit in a similar way to that in midwifery. There has been an attempt to define this unique contribution from about the 1980's; this work has led to a way of framing theory based on models. Burnard (1990) states that professions need knowledge bases and that one means of securing a knowledge base is the development of theory. However, he challenges the prolific development of theory which has appeared in nursing relatively recently as being ungrounded or not tested empirically. This sets a challenge for theorists to be able to clearly articulate the origin and basis of the theory as well as being able to demonstrate its usefulness in

practice. Burnard (1990) claims that current nursing theories tend to be fairly grand in their conception and, because of this, very difficult to test. These theories in nursing have taken the form of conceptual models, for example Orem (1971) and Roy (1976), who discuss nursing processes as a means to increasing a systematic approach to the provision of care. However, rather than facilitating growth in practice, they appear to have constrained it by dictating set patterns of activity to be implemented in certain situations or conditions. There may be a difference in 'theory for' and 'theory of'; these nursing models can and often are treated as prescriptive and rigid (theory for) rather than interpreted more flexibly to help explain situations and inform action (theory of).

The interpretation of theory as models in the nursing literature may be a limited concept of theory which does not necessarily help practitioners to think and understand. Midwifery has not adopted this approach to theory and has generally shunned the idea of models as devaluing the individual woman's experience. Price (1993:233) identifies that the relationship between theory and practice, especially in midwifery, has always suffered a certain tension. He suggests, however, that theory and research pursued with insufficient reference to clinical needs may be "akin to the modern Voyager space missions. New worlds may be discovered but the news will be transmitted back to earth in ever weaker messages!" If the theory is not rooted in practice and not useful to the practitioner, these attempts to characterise the phenomenon may become an academic exercise with little value to those trying to underpin practice with appropriate theory.

Midwifery Theorists

Bryar (1995) describes five midwife theorists who have contributed to theoretical concepts relating to midwifery. These theorists, however, with the exception of Wiedenbach, have focused mainly on issues to do with childbearing women and the care offered to them rather than on the essential bases of midwifery practice. Rubin (1967) looked at the attainment of the maternal role in her research identifying four tasks relating to the adoption of that role; the only reference to the midwife was as a possible role model for the pregnant woman in offering information which facilitated the transition. Mercer (1981) considered the stress involved in becoming a mother, identifying a series of variables which affect the role adjustment; none of this work was directly related to midwifery. Both of these theorists were focussing on theories of

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motherhood rather than midwifery. Although the two are inextricably linked, this theoretical work does not make a significant contribution to understanding the underpinning theory of midwifery.

Lehrman (1981) identified concepts relating to antenatal and intrapartum care and did articulate aspects of the midwife's role which proved helpful to women in these periods; these concepts are useful to midwives in the sense that they give some evidence as to what women appreciate in the way of care. Ball (1987) promoted the 'deck-chair theory of emotional well-being' which related primarily to issues which impacted on the woman's wellbeing; these included the woman's personality, personal sources of social support and the care offered by the maternity service. There is some link to the role of the midwife in the latter with guidance for midwives on areas of intervention which are perceived as supportive by women. However the work of these two theorists also relates significantly to the experience of care for the woman rather than articulating the unique contribution of midwifery practice.

All of these sources explored areas of great significance to midwives and to midwifery as the foci were on the care provided to and the experience of childbearing women, which is obviously the role of the midwife. However none looked at midwifery from a midwife's perspective nor attempted to articulate the theory (accounting for or characterising the phenomenon) of midwifery practice as such.

Wiedenbach (1960) approached the concepts which underpinned both nursing and nurse midwifery practice (she was an American) from a more theoretical stance. Some of the points she raised were very insightful and relevant; she suggested that theory is inextricably interlocked with practice, underpinning it and being responsible for its character and quality. She includes the theory of accountability as a basic premise to practice - the accountability for both what the nurse (midwife) does and the ultimate results of her / his actions. She also focuses on the role of intuition in practice, a professional intuition which is influenced by knowledge, judgement and a respect for the patient and the effect care may have on her or him. She describes this integration of observation and intuition with knowledge as the art of nursing. Wiedenbach is recognised as having made a significant contribution to the development of midwifery theory by drawing out and helping to explain the factors which contribute to skilled

practice (Bryar 1995). However, despite her work having been undertaken some fifty years ago, the impact of it on midwifery in this country appears limited. Until I began work on this thesis, I had never heard of Wiedenbach nor her concepts. Her theoretical work does not appear to have been adopted to any significant degree by current midwifery theorists in the U.K. In addition, it is not unique to midwifery; all of the concepts which she has explored relate as significantly to nursing as they do to midwifery.

Physiological Theory of Midwifery

Interestingly, none of these theorists have primarily focused on the physiological or clinical aspects of midwifery practice. This may be a reflection of the relative lack of importance associated with the 'scientific' side of practice, possibly as a reaction against the priorities associated with medical, obstetric practice. Physiological knowledge is largely omitted by these theorists who have dealt with the 'softer' side of the woman's experience and not with 'hard' science. Physiology would appear, almost by default, to be considered the domain of the doctor; physiology is not normally recorded as formalised midwifery knowledge but considered as 'borrowed' from the medical domain. This phenomenon is relatively easy to understand having considered the development of knowledge of childbirth, which became dominated by medical men in the 1600 and 1700's, as discussed in chapter two. The unique contribution that midwifery physiological knowledge makes to the understanding of birth would seem to be largely ignored as it is not formally recorded and remains largely unresearched. I will provide a few examples to clarify what I mean and consider the potential significance of this situation.

Examples of attempts to examine physiological phenomena which midwives may have traditionally used as indicators of progress in labour are starting to appear. These include the 'purple line' which Lesley Hobbs describes, a line on the perineum as an indicator of descent of the presenting part during labour (Hobbs 1998). This phenomenon could be critically important as, if adopted as a routine measure of progress, women could be relieved of the need for regular intrusive vaginal examinations in labour. In addition, an Australian researcher is trying to challenge the current use of the partogram in labour in order to reduce intrusion to women by defining alternative measures of progress (personal communication). The partogram is

a graphic representation of the progress through labour with two key determining factors defining progress, the dilatation of the cervix and the descent of the presenting part. Both of these are measured by vaginal examination and compared rigorously to the clock; if the cervix does not dilate at approximately one centimetre per hour, intervention takes place. The Australian researcher is proposing a replacement of the measurements elicited through vaginal examination with a recording of the woman's facial expressions as these change significantly through labour and may provide a similarly non intrusive way of monitoring progress as the 'purple line' does.

A third example comes from a personal experience. As a midwifery lecturer with a link to an NHS Trust some years ago, I was asked to do some sessions with nurses on the gynaecology ward as they wanted to learn about labour. Although these nurses do not care for women at term in normal labour, they regularly support women experiencing late miscarriages or terminations. They felt there had been a gap in their training and that they were inadequately prepared to provide appropriate support to these women. They understood the physiological processes the women were experiencing but knew little of how this would be demonstrated and how the woman's behaviour should be interpreted. In preparation for these sessions, I looked through some sources on labour to decide how best to handle this. I found ample facts on the physiological and psychological aspects of labour; unfortunately I could not find anything helpful which I could photocopy for these nurses as handouts that would describe what they would see in the women they were caring for and help them to determine progress. Midwives use a variety of observational skills in supporting labouring women, including watching their behaviour, listening to the noises they make, undertaking abdominal and vaginal examinations and monitoring vital signs. Nurses caring for women aborting a fetus do not undertake abdominal or vaginal examinations (which text books describe in great detail) and are therefore left with the visual and auditory skills with which to assess progress. Nowhere could I find written reference as to what to expect at certain stages in labour from these two perspectives.

The truth is that I did not need written reference to be able to describe what to expect as a woman progresses through labour. In these sessions, I demonstrated movements, facial expressions and noises which could be expected at certain points in labour. The experienced nurses could understand this; they had seen women

behaving in the ways I was describing but had not previously been helped to make the connection between the changes the woman was experiencing physiologically and her pattern of behaviour. My experience as a midwife had led to the development of 'tacit knowledge', 'intuition' or 'expert knowledge' which had been inaccessible to these nurses as, despite it being common knowledge to midwives, it is not frequently formally recorded in text books and sources on labour.

If articulated clearly, these examples of many possibles, could help to identify the contribution that midwifery knowledge makes to the support available in childbirth. However this type of knowledge has largely been ignored in a society where 'scientific' knowledge takes highest priority. Despite the recognition from as early as the days of Jane Sharpe (Hobby 1999), that midwives had a knowledge of physiology and the ability to use it, this aspect of theory seems to have been handed over to medicine along with curing (as discussed in chapter two). The less status-full caring or 'softer' side would seem to have become the significant focus of midwifery theorists.

Bryar (1995) identifies the importance of drawing on theory from other disciplines in midwifery and includes physiology as one such source. She pulls together, along with physiology, a variety of contemporary theoretical perspectives on midwifery but falls short of defining a grand theory to guide the profession. She leaves the interpretation of these to the individual midwife by suggesting that each midwife must define her / his own theoretical base in the context of practice. Although this may seem admirable, it would also seem a very challenging suggestion and one which many midwives would find difficult or impossible to do. The evidence to confirm the difficulty associated with this approach would seem to be the lack of explicit theory, in some aspects of midwifery, available to guide midwives in practice.

Theory Development

It would seem from this discussion that there are some points to bear in mind on the path to theory development. Theory exists (or else practice would not) but it is essentially embedded in the practitioner and may be difficult to make explicit. The extraction and articulation of the theory base for practice may enrich it but there are certain pitfalls to avoid in the process. Complicated models which are not grounded empirically may constrain rather than free practitioners. Theory which is not based

directly in practice may be too irrelevant to be meaningful to those for whom it was intended. Theory which is not communicated widely and adopted by the practising community may fail to have a significant impact on practice. Leaving the individual practitioner to define her / his own theoretical base may also be problematic and lead to poorly articulated and understood fundamentals for practice. In contrast, concepts which are both familiar and useful to the practitioner and arrived at through rigorous research would be a sound basis of any theory generation.

Concepts are the building blocks of theory; they are "classes of ideas and things in the world.... (which) can be applied to an idea, an event or a group of objects" (Bryar 1995:26). Moody (1990:148) adds to this definition by claiming:

> Concepts are linguistic labels that selectively categorise elements of reality. Concepts are mental images that help organise the facts in our world, thus enabling us to go about our daily activities in a more orderly fashion. Concepts are not real but invented to represent reality.

In the remainder of this chapter, the concepts which are currently being discussed in the midwifery literature will be considered. Reviewing those concepts which are considered important will help to determine where the gaps are within the overall theoretical base for midwifery.

Contemporary Issues in Midwifery Literature

This section presents the findings from a comprehensive review of issues being raised, discussed and debated in the contemporary literature. With the absence of a clearly defined theoretical base for midwifery to underpin the educational strategy, I explored those issues which appear important to writers and researchers in midwifery as a starting point to defining key theoretical concepts. These are presented and discussed, relating back to pertinent points already raised in the previous chapter as appropriate. This chapter helps to define the 'what' student midwives should be learning before exploring 'how' they learn in chapter four.

The Review Process

Preparation for this chapter began in 1996 when I was initially writing my research proposal and then subsequently trying to clarify what was considered important by

contemporary authorities, researchers and writers on the subject of midwifery. At that time, I undertook a very large manual search of the major midwifery journals and some texts from the U.K. and the U.S. As I couldn't and didn't want to anticipate what others thought were the important issues in midwifery, I spent many hours scanning, copying and filing articles and chapters under themes which appeared frequently in the writing. There appeared to be main two thrusts - the factual and the more esoteric. In keeping with the historical debates around childbirth, I started to identify a 'scientific' theme and one which was more 'artistic'. I found that the writers who were raising significant debate in the literature appeared to be focussing more on the latter than the former at that time. Evidence based practice was an emerging concept in the medical literature and there was a growing research base on midwifery subjects appearing but the more human, interpersonal issues appeared often in the literature. My initial writing in that period reflected that emphasis.

When I returned to the literature in 2001 to restructure and further develop that initial writing, I observed that there had been a massive growth in the literature. Evidence based practice had increased substantially as a theme; risk and risk management (often in relation to litigation) in maternity care and the wider clinical governance agenda had appeared as dominant issues. I continued with my original approach of manual scanning but, having identified original themes, I was able to use database searches to enhance this. One very interesting development had been the change in the number and range of pre-prepared searches available from the midwifery information service, MIDIRS. I found that there were many more searches available within the same broad categories; the total number of available searches had changed from 303 in June 1996 to 419 in June 2001, an additional 116 searches. The range and content of the searches (for example, 17 new ones on complications of pregnancy, 5 new ones on interventions in labour and, in the 9 new ones in relation to the maternity services, the titles clinical governance, risk management and feminism / gender issues had appeared) reinforced my belief that a shift had taken place. Authors and researchers continued to discuss 'artistic' issues and, alongside, there was a growing body of opinion which challenged the 'scientific' or biomedical approaches to childbearing and its impact on midwifery. In addition, the empirical research around childbirth had increased substantially in quantity and quality in the intervening period. I accessed a number of relevant searches to ensure I had explored an appropriately

wide range of sources, both within midwifery and other sources, in reviewing the literature.

This review is a structured discussion of concepts and it reflects the two broad themes of 'science' and 'art'. These two terms are used in the literature quite frequently and suggest two opposing constructs for issues pertinent to midwifery practice. They appear to provide an appropriate framework in which to situate a discussion of current priorities of the writers in midwifery.

Of course, I have had to be selective in the issues raised in this chapter but my choice has been based on the frequency of the concept appearing in the literature, the number of writers addressing it and the strength of argument associated with it. The use of reference to sources should assure the reader that the points raised are indeed significant to midwifery, midwives and women going through childbirth. In addition, I have sought confirmation from my supervisors and colleagues that I have raised key concepts in the discussion. As I delved into the themes, issues have led me to tangential but equally significant debates in related literature. These will be included in the discussion to explore further the concepts important to contemporary midwifery.

Science in Midwifery

Science, as discussed in chapter two, is considered to be an 'organised body of knowledge that has been accumulated on a subject; systematic and formulated knowledge; dealing with material phenomena and based mainly on observation, experiment and induction" (The Concise Oxford Dictionary 1982). As discussed earlier, Marriner-Tomey (1989:3) indicates that 'observation, identification, experimental investigation and theoretical explanation of natural phenomena' is the purpose of science. Chinn & Kramer (1991) suggest that science is both an approach to the generation of knowledge and the results of using that approach. The approach for generating that knowledge is referred to as scientific enquiry and Powers & Knapp (1990) identify that research for the advancement of knowledge and theory development in an effort to provide descriptions, explanations and predictions are the underpinning principles. Peplau (1988) suggests that there are particular values associated with the scientific method including scepticism, doubt, objectivity and detachment; Reed & Procter (1993) claim that it is these values which afford scientific

knowledge its high academic status as a superior way of knowing. Ideally scientific knowledge should always be considered as provisional, always ready to be exposed to further scientific challenge or scrutiny. However, in practice, this does not seem to be the case; scientists tend to work as though current knowledge is definitive.

Science is considered to be definitive and authoritative knowledge as was highlighted in chapter two; several branches of 'hard' (basic or natural) science are relevant to birth - biology, physiology, biochemistry- all play a part in the understanding of the processes surrounding reproduction. Despite the challenge to broaden this perspective posed by those in the 'softer' sciences such as sociology and anthropology, the current dominant approach to birth in Western culture is driven by the higher priority afforded scientific and biomedical knowledge as the authoritative paradigm. The scientific or biomedical perspective on birth has had an increasing impact over the centuries and as "medical and scientific knowledge gained authority, the humanistic knowledge of the social sciences found it increasingly difficult to compete for recognition on the same terms" (Siddiqui 1997:97).

Science is included in this review as it is a theoretical perspective which informs some significant concepts in the midwifery literature. The next sections consider concepts within this perspective which largely reflect the biomedical approach to childbirth.

Science and Health

Birth is not the only sphere of human experience which is implicated in the scientific movement. The contemporary view of birth stems from a much wider set of beliefs surrounding the notion of health and its relationship to medicine. Townsend and Davidson (1992) provide an account of the historical development of this relationship. They suggest that from the times of ancient Greece, there have been two main meanings to the word 'health'. One was derived from the followers of Asclepius who believed that health was "freedom from clinically ascertainable disease" and that the main role of the physician was "to treat disease and to restore health by correcting any imperfections caused by accidents of birth or life" (Dubos cited in Townsend and Davidson 1992:33). In contrast, the followers of the goddess Hygeia believed that rational, social organisation and rational individual behaviour were all-important to the promotion of human health. Happy and harmonious relationships underpin this

approach which accepts that the purpose of medicine is to "discover and teach the natural laws which will ensure a man a healthy mind in a healthy body" (Dubos in Townsend and Davidson 1992:34).

Foucault in his 'Birth of the Clinic: An Archaeology of Medical Perception' (1973) describes the transition which occurred in the nineteenth century when there was a distinct move from holism to localisation, with diseases being organised into a set of symptoms in various parts of the body rather than as a lived experience for the whole person. Medical practitioners developed particular skills in observation of these symptoms ('the gaze') and objectified the experience of illness. "In order to know the truth of the pathological fact, the doctor must abstract the patient" (Foucault 1973:8). Surveillance as a concept was brought to life for Foucault through the 'Panopticon', an architectural machine of power conceived by Jeremy Bentham, in which the individual was placed in view at all times with the gaze of authority placed on him by hidden observers (Woodhams 1992). This surveillance continues to be a major feature of twenty first century maternity care, with the fetal cardiotocograph recording being observed centrally within a delivery suite as a prime example (see section on Risk and Risk Management for further discussion).

The focus on normality as the absence of disease (as per the followers of Asclepius) in contrast to holistic health (as per Hygeia's stance) presents a philosophical stance underpinned by a scientific rather than social reality. The observer becomes crucial to the confirmation of normality as there is a need for external surveillance to monitor the presence or absence of disease (it's insufficient just to feel well to be healthy, there may be pathology lurking within). There is a power dimension in observation / surveillance. Foucault (1977) points out the power which the observer holds over the observed; individuals are transformed into objects of knowledge over which authority can be exerted. Antenatal care is an ideal example of this surveillance; a pregnant woman attends clinic throughout pregnancy in order to be examined and observed by the midwife or doctor who then tells her whether or not she is 'healthy', even in the absence of any symptoms. The midwife or doctor can then exert control over the behaviour of the woman by providing advice about lifestyle (one of the forms of discipline to which Foucault alludes), putting the practitioner in a position of relative power over the woman.

These two contrasting perspectives of health (absence of disease versus personal / social organisation), with their differing power bases, have been described as the 'medical model' and the 'social model' of health (Thorogood 1992). The medical model of health has gained power through the ages as the understanding of the functions and physiology of the human body has increased. It has led to a mechanistic perspective in which the body is conceived as a machine which can be effectively repaired by practitioners with the appropriate knowledge and skills (Black et al 1988). It relies heavily on scientific knowledge which is generated through experiment and creates the belief that with enough investigation, the solutions to all health situations can be found.

A consideration of these two perspectives is important in a review of contemporary midwifery concepts as they underpin the philosophies of the key players in the maternity services. They also help in an understanding of the influence of medicine over the social phenomenon of birth.

Medicalisation

Medicalisation is a sociological term which purports that there is an increasing tendency for medicine (and the medical profession) to expand its claims (Hillier 1991). More and more of human life and its social processes have become defined and controlled by medicine. There is an extension of the range of social phenomena mediated by the concepts of health and illness leading to an expansion of professional power over wider spheres of life (Crawford 1980). Childbirth is an example of this medicalisation phenomenon which has been discussed at length in the literature; a number of the most noted will be referred to here.

Van Teijlingen et al (2000) expand the concept to describe the medicalisation of childbirth (and midwifery) as the increasing tendency of women to prefer a hospital delivery to a home birth, the increasing trend towards the use of technology and clinical intervention in childbirth and the determination of medical practitioners to confine the role played by midwives in pregnancy and childbirth to a purely subordinate one. Oakley (1980) has shown in her studies of childbirth how the medical profession has redefined childbirth as a potentially pathological process, requiring increasing levels of medical intervention and control. "The professional obstetrical view that

childbirth is a pathological process and women are passive objects of clinical attention has become an integral part of the way in which the community as a whole sees childbirth " (Oakley 1993:119). This way of 'seeing' childbirth relates to the accepted authoritative knowledge within society. Jordan identifies that, despite several knowledge systems existing in any given society, there is one which is normally thought to 'explain the state of the world better for the purposes at hand (efficacy) or is associated with a stronger power base (structural superiority), and usually both' (Jordan 1997:56). Biomedicine is the current authoritative knowledge associated with birth in Western cultures.

In the name of promoting the safety of birth for mother and baby, pregnant women have been persuaded to comply with an increasing range of medical procedures, treatments and protocols (Young 1995). Davis-Floyd (1995) concluded from her interviews with women, obstetricians, nurses and midwives in the U.S. that the technocratic American society has created a set of obstetric rituals which have reframed the birth experience completely, following the particularly effective propaganda campaign described in the section on 'Midwifery in the U.S.' in chapter two. The symbolic American procedures of seating labouring women in wheel chairs when they arrive in hospital, putting them to bed on admission to the delivery suite and attaching intravenous infusions routinely all communicate the message to women that they are not just pregnant but sick. This technocratic myth insists that the more nature is controlled, the better it gets and that the ultimate control of nature is not only possible but desirable. Medicine has moved from therapeutic intervention to a mechanism of social control.

There is a growing body of literature in which medicalisation is challenged, suggesting that the routine use of interventions (largely unsupported by evidence derived from experiment or investigation and therefore fundamentally 'unscientific') is negatively impacting on women's experiences of birth (for example Anderson 2000a, Davies 2000, Murphy Lawless 2000, Cowie & Floyd 1998, Beech 1997, Hoope-Bender 1997). The need for midwives to advocate on women's behalf, to slow this wave of change to highly technical, managed births is a plea from many writers who are interested in keeping birth 'normal' (Righard 2001, Page & Sandall 2000, Day-Stirk 2000, Fahy 2000, Simpson 1999). However the definition of 'normal' childbirth seems unclear

when, most commonly in the West, there is some intervention in virtually every birth experience. The constructs of 'normal' and 'natural' are debated, highlighting the changing descriptors in a culture which expects analgesia, augmentation and electronic fetal heart monitoring, for example, as norms in labour (Downe 2001, Weston 2001, Beech 1997). Many authors believe passionately that women can birth without intervention but this requires a suitable psychological environment (Lothian 2000, Beech 2000, Warshall 1997, Markus 1997, Hancock 1996, Nolan 1996). However women's (and midwives) confidence in the physiological process of birth is undermined in a climate of fear of recrimination and litigation (Shallow 2001).

Obstetrics

The biomedical model of childbirth is embodied in the obstetrician who is defined as the specialist medical practitioner responsible for caring for childbearing women when there is deviance from normality. The word obstetrics is derived from the Latin 'obstare' which means to stand before (Arney 1982); the mental image which this creates appears somewhat different to that of the midwife 'being with' the woman. Walker (1976:130) presented a particularly relevant definition: "Obstetrics is a term used to cover the application of scientific knowledge to assure as far as possible the physical wellbeing of the mother before and immediately after the birth". Although it can be argued that much of obstetric knowledge and practice is not really scientific, this definition helps us to recognise the accepted perspective of medicine as scientific. As Bevis (1989) suggests that science gives us the tools for curing, obstetrics is therefore the branch of medicine which provides cures to the ailments associated with childbearing (and gains the status attached to curing as opposed to caring).

As childbirth has been increasingly medicalised, obstetricians have increasingly taken control of the care provision for women in pregnancy and labour (but have actually had little interest in the puerperium leaving the adjustment to parenthood primarily to others including midwives). The role of the obstetrician and midwife are, in theory, complementary. The former is concerned with 'safe delivery' through the application of scientific knowledge with the emphasis on prevention and treatment of the abnormal (as per Walker's definition above). The latter is concerned with the wider aspects of childbirth as a normal experience, based on an understanding of normal physiology, in which the provision of emotional support and preparation for both childbirth and

parenthood are integrated into overall care. The midwife, ideally, works with the same clients before, during and after childbirth and develops a close and supportive relationship with those women (see section on Continuity of Care and Carer). When the circumstances surrounding the childbirth experience are no longer considered normal, the obstetrician takes over responsibility and the midwife acts under his / her direction.

Although this approach to providing care for childbearing women appears on the face of it quite appropriate, the truth is that with the increasing tendency towards women giving birth in hospital in Britain since the 1960's, obstetricians have become increasingly involved in normal childbirth. For ease of administration and organisation (it is said), the majority of women having babies today are 'booked' under the care (and therefore authority) of a consultant obstetrician (although midwife-led care initiatives have started to change this). The rationale is that this makes the maintaining of records, structure of antenatal clinics, covering the delivery suite with a team of doctors and division of clients onto the postnatal wards simpler to coordinate, as all of the women attending a particular maternity unit are divided up into groups based on the number of consultants employed at that unit. The effects reach far beyond administration, however, as these doctors will have been schooled in the biomedical approach to childbirth, with its emphasis on surveillance as a means to detecting abnormality (to be discussed further in the section on risk). As they are administratively in control, their perspectives are likely to impact on the type of care offered to women regardless of whether the woman's experience is deemed normal or not. The profound redistribution of manpower and responsibilities in the maternity services, giving authority primarily to consultant obstetricians over general practitioners and midwives, has impacted on the general perception of childbirth as an 'obstetrically engineered' event (Schwarz 1990).

Medical versus Social Model

Bryar (1995) suggests that there are two main approaches to pregnancy prevalent in maternity care; the 'pregnancy as a normal life event' versus the 'obstetric model of pregnancy'. Characteristics of the obstetric model include perceiving the unusual as interesting, only believing that birth can be normal in retrospect, emphasising the prevention of physical complications with the significant ultimate outcome being a live,

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healthy mother and baby. In contrast, pregnancy can be considered as normal in anticipation, a socially and culturally-situated unique event for each woman and baby and an opportunity for the development of personal and social self through the change process. The desirable outcome in this scenario relates to satisfaction as well as health.

Although it cannot be assumed that all obstetricians sit firmly in the camp of the medical model of pregnancy (and childbirth), it is easy to see why the majority would. The education of medical students includes a rotation to a maternity unit where they become involved in providing care for labouring women and helping them to give birth. A common experience is that they are expected to 'deliver' 10 women during that period of time and therefore do gain some insight into the experience of normal birth (although this almost exclusively takes place within a hospital and not at home). However, if they then choose to follow a career in obstetrics, they will have little further opportunity to participate in normal birth situations. Midwives 'deliver' approximately seventy percent of women in Britain (Page & Sandall 2000), those whose experience is not complicated. In those cases, the obstetrician is not normally directly involved in the labour to any significant degree. Therefore, by the time the obstetrician reaches the level of consultant, he or she would have spent six months as a senior house officer, possibly two or three years as a registrar and another two or three years as a senior registrar only dealing with complicated births. The experience as a medical student would seem a distant memory and the overwhelming sentiment is likely to be that birth is a dangerous experience as there would have been six or seven years of reinforcement that things can, and do, go wrong during labour. There would be little opportunity to contextualise that belief as there would seldom be the experience of participating in normal birth situations. Constant negative feedback will almost inevitably lead to an image of birth as a 'disaster waiting to happen'.

There is a lively discussion in the literature about the opposing ideologies of childbirth and maternity care; the desirability of challenging the medical dominance and moving away from obstetric birth to woman-centred care is supported by many (Pincus 2000, Powell 1999, Rothman 1999, Bennett 1997, Churchill 1995). Gregg considers this paradigm split as 'high tech' and 'low tech'; following indepth interviews with 31 women, she identifies that perception of either is very individual for both women (one woman's

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low tech is another woman's high tech) and for health professionals. The personal perception, as well as standardised practice, will affect the way the professional provides information to women as part of supporting choices around childbirth.

> Once a medical technique becomes routinised, the element of choice regarding its use can become obscured or overlooked. Standard medical protocols can lead to a priori assumptions on the part of doctors and their patients about the necessity for particular procedures.
>
> Gregg 1995:3-4

Just as it cannot be assumed that all obstetricians approach birth from a medicalised perspective (although it is understandable as to why the majority would), it also cannot be assumed that all midwives consider pregnancy and birth as a normal life event. A midwife's experience will also colour her impression of birth and will influence the type of care she or he offers women. Experience, however, is only one form of evidence on which practice is or should be based.

Science as Evidence

Despite this discussion highlighting some limitations that a biomedical view of childbirth can have on women's experiences of childbirth, there can be no doubt that safe midwifery practice is based on a scientific understanding of physiology. Silverton (1993) suggests that science is an essential element in midwifery which underpins effective practice. There are two main purposes for this scientific knowledge - the ability to support normal physiological and psychological processes (for example, labour, birth, breastfeeding, adjustment to parenthood) and to detect deviation from the norm. If the midwife is the practitioner who is to define normality and when it is appropriate to refer to medical colleagues, she or he must understand the underlying processes in order to determine this. The detection of complication is a key skill in midwifery in order to ensure optimum care for women; this skill is based on knowledge and understanding of scientific principles. However, as discussed earlier, current physiological knowledge taught to midwives is frequently framed from a biomedical perspective, with midwives' intuitive or expert knowledge of physiology largely being unrecognised or under valued.

In addition to an understanding of the physiological and psychological principles of the childbirth experience within the social norms of the culture, midwives need to understand the rationale and justification for care offered to women. Increasingly the rationales are coming from research, although it is recognised that a significant proportion of current clinical interventions remain unsubstantiated by empirical evidence (Page 1996). Midwifery, as a profession in Britain, has explicitly recognised the value of underpinning practice with research evidence by modifying the Midwives Rules to include a point in Rule 33 (dealing with courses leading to qualification as a midwife) which requires the student midwife to 'be able to use relevant literature and research to inform their practice of midwifery' (UKCC 1998). Despite this recognition, Mead (1996) illustrates the lack of a research base for practices, like the routine pattern of antenatal care, commonly provided in Britain today. She suggests that midwives and other health care professionals use a variety of sources upon which to base their practice in the absence of research findings including tradition, experience, authority, common sense and trial and error. Following set routines which are custom and practice, based on tradition rather than contemporary evidence, in a clinical area, seems an easy path to take. Page (2000) points out that much of effective and appropriate care is concerned with the move from set routines towards care that is thoughtful and individual. This care should be based on evidence which comes from a variety of sources- the woman's expectations, the clinical examination, research and reflection.

Science as evidence, therefore, would seem to be only partly helpful to midwifery practice. Many medical interventions are considered as 'scientific' but may not actually be so, reflecting common practice and understanding of the day rather than being based on empirical evidence.

Evidence Based Practice

An important concept, which has originated in medicine and is now significantly impacting on midwifery practice, is that of evidence based practice. Muir Gray (1997:213) defines evidence based clinical practice as 'the judicious use of the best evidence available so that the clinician and the patient arrive at the best decision, taking into account the needs and values of the individual patient'. This suggests an

integration of the understanding of research evidence with the interpersonal and decision making skills required to help the woman make choices.

The move towards evidence based health care (Sackett 1996) has been accepted as a positive step by many midwives in an attempt to reduce conflicting advice for women and therefore the confusion which often surrounds decision making in childbirth. Page (1993) suggests that midwives must become familiar with the 'scientific' evidence available to them and be able to evaluate the costs and benefits of various forms of care if they are to give women the information they need to decide between alternative treatments and approaches. This would seem a very appropriate rationale for adopting an evidence based approach to care, however, it does beg the question as to what 'scientific' evidence is, as there are divergent interpretations of this concept. As Page suggests, evidence based practice can be a helpful tool for midwives if used effectively; however the nature and value of differing types of evidence demonstrate a definite contrast in perspectives, reflecting the medical and social models of health.

The randomised controlled trial (RCT) has become the gold standard of evidence for many doctors and those influenced by the medical model. This approach to research, reflecting the positivist paradigm, is based on experiment in which two groups are randomly allocated either to receive an intervention or not. Large numbers of participants are required to determine that any benefit is not as a result of pure chance. This experimental, quantitative approach to research is "classified by many scientists as the only true type of research" as "variables are identified, controlled and some manipulated by the researcher" (Mead 1996:134). The RCT offers an important source of evidence and one which is widely accepted as conclusive if implemented with appropriate rigour, especially in the 'scientific' community. However, it is merely one way of researching and those who accept a more social perspective on health and birth, embrace a much wider spectrum of research methodologies (some of these will be further discussed in chapter five). Much of the midwifery research literature demonstrates a sympathy with this social perspective as qualitative studies are prevalent; RCT is one of a large number of research methods which are respected as valuables sources of evidence in midwifery.

There are positives associated with evidence based practice which should not be ignored. The large increase in both research activity and the reporting of it (for example Enkin, Keirse and Chalmers 1989, Cochrane Collaboration 1998) has led to many aspects of care which have been found to be unhelpful being abandoned despite them having been in common practice in the past. Unfortunately this is not a consistent pattern and there are many examples of routine care still being provided despite there being robust research based evidence to the contrary [for example, routine electronic fetal heart rate monitoring in low risk labour (NICE 2001, MIDIRS 1995)].

The current agenda in maternity care has been influenced by the improved understanding of physiology around childbirth and the increase in available research evidence (recognising that there is still progress to be made in this area). The emphasis on and availability of research evidence has been supported by systematic literature reviews and publication of these in both hard text and via computer data bases. There is clearly much more research-based knowledge which can inform midwifery practice easily accessible to the majority of practitioners in the U.K. today than in the past. Accessed and interpreted effectively, this can have very positive outcomes for women's experiences. However one of the negative impacts of the evidence-based culture is the rise of the concept of risk. Statistical evidence is increasingly being used as a rationale for recommending interventions which may be perceived as 'safer' but which may not make the childbirth experience more satisfying. This change is likely to be reflective of wider change in society where risk is seen increasingly as a means to shaping individual behaviour to conform to social norms.

Risk

> The concept of risk has come to assume increasing prominence in sociological writings on late modern society, witnessed by the proliferation of socio-cultural analyses of risk and of studies which have explored the implications of a new risk consciousness for personal conduct.
>
> Petersen 1997:189

This change is reflected specifically in relation to midwifery as well as more generally. Risk consciousness affects all of Western society, however the following discussion will focus on the impact that this construct has on maternity care, women and midwifery practice as an exemplar of the general change in society.

Risk is a word that has been used increasingly over the past decade in relation to childbirth. In the 1984 edition of Mayes Midwifery (Sweet 1984), the word risk is only used to identify the fetus who may be compromised by 'fetal distress' or hypoxia. In the 1997 edition of the same book (Sweet 1997), the concept of risk appears much more frequently in relation a whole variety of issues: amniocentesis, breech presentation, shoulder dystocia, preterm labour and Caesarean section as examples. This change in the midwifery literature highlights a general trend in maternity care; we are much more focussed on (and therefore potentially constrained by) the concept of risk. The terms 'risk management', 'antenatal screening for risk of abnormality' and 'risk criteria for midwife-led care' surround us; we are now in a position where we label far more women 'at risk' than in the past. However, the potential of complication ('at risk') rather than the actual presence of it (diagnosed complication) may blur the lines of responsibility and make very large numbers of women who are, in fact, perfectly well at the moment begin to believe that they have a problem.

Most women come into a pregnancy full of anticipation and excitement; they value midwives who are able to help them to feel 'special' and unique (Hutton 1994). This positive feeling, however, can be quickly changed when, at the booking appointment, the woman is introduced to the concept of risk in relation to her imminent experience. As part of her introduction to antenatal care, she will be offered screening tests which may help to determine whether her baby is 'normal'. It may have never crossed her mind that the baby would be anything but 'normal' and she has to try and make sense of the meaning of being 'at risk'. Instead of feeling like a unique individual, she will have to think of herself as a statistic; a member of an 'at risk' population by virtue of being pregnant. If she chooses to undergo the tests on offer, she may find that she is presented with figures which are difficult to comprehend. The midwife is key in helping her to decipher this quagmire and, because of this, the midwife herself must understand and be able to clearly articulate these complex concepts. The woman may need help to come to grips with how significant this risk really is for her as an individual.

Epidemiology is "the study of the distribution and determinants of disease in human populations" (Barker & Rose 1984). The distribution of the disease is described in

relation to the frequency of the condition over time, by person and by place (Tannahill 1997). Statistics are collated which can be used to predict the likelihood of the disease and its possible outcome. The determinants of the disease relate to the hypotheses on causation; case-control and experimental studies are used to define risks in certain populations (Tannahill 1997). Both of these issues are important inputs into the public health agenda. Analyses can help to inform the effective use of resources in reducing diseases and the impact of them. However, epidemiology is based on populations, large numbers of people grouped in a variety of ways to gain information which can be used in targeting groups. This generalisation approach is at the heart of risk and the scientific management of it. Interpretation of generalised findings into an individual situation is, at best very difficult and, at worst completely unhelpful. Epidemiology would never lay claim to explanatory power at the level of the individual but the risks determined through epidemiological studies are used as the basis for decisions about individuals by clinicians.

There is a significant impact on midwives in implementing the concept of risk when providing care for women in pregnancy and at the time of birth. Midwives are considered to be the vital mediators in childbirth (Kitzinger 1988). This mediation starts at the beginning of pregnancy when midwives must help women to make sense of the services offered to them. This means being able to translate difficult concepts like the statistical risks involved in screening into something meaningful to the individual woman in her personal, social and cultural situation. It also means supporting the woman's choice once she has made sense of the best option for her as an individual. In a recent survey by the NCT, it was found that some women feel that their rights to choose not to have antenatal screening are undermined by professionals who do not accept the decision to forego any testing (Dodds & Newburn 1997). Women can be disempowered by lack of sensitive awareness as well as by lack of appropriate explanation.

Many aspects of antenatal care, including prenatal screening tests, have the effect of making all women potential cases of risk. They are at risk by mere virtue of being pregnant; the increased availability of tests (or surveillance mechanisms, as per Foucault 1991) means there is ever-increasing availability of statistics which demonstrate how dangerous pregnancy can be. This is in keeping with the medical /

obstetric model of pregnancy which suggests that it can be considered 'only normal in retrospect' (Bryar 1995); the medical 'frame of reference' (Graham & Oakley 1991) locating pregnancy as an 'isolated medical event'. With this backdrop, risks are seen everywhere. Lane (1995:59) points out that "the imposition of a risk category on all women acts as a form of micro-social regulation bringing about acquiescence to medical intervention. It is true that the majority of women are deemed medically low-risk cases, but the very term 'risk' implies the probability of mischance." The current approach to antenatal care is escalating the control over women by medicine in a way unprecedented in history, despite pregnancy and birth always having been considered as times of risk (for example, Hobby 1999). However the historic concept was much broader; the interpretation of risk in current obstetric practice is very focussed on the reduction of 'abnormality' including both maternal and neonatal disease and congenital abnormality. Complicated statistics which are difficult to interpret and increasingly complex, testing for relatively obscure conditions, often needing highly specialised knowledge and equipment, seat the medical practitioner in a very powerful position.

Women may feel compelled to participate in tests which are offered to them as many believe that professionals should know best. Once the woman is defined as high risk (even though a complication has not been diagnosed), midwives might feel that the care is outside of their province with the doctor taking charge. As risk is dominating antenatal care in this country, there may be significant effects on the relationship between woman and midwife, compromising the autonomy of midwives (recognising that this has already been limited by the position relegated through the Midwives Act, discussed earlier) and disempowering women. DeVries (1993) proposes that the introduction of risk as a significant concept in the care of childbearing women could be the downfall of midwifery, as he believes that an occupational group gains power to the extent that it can reduce or manage risk and uncertainty in others. Despite the 'Midwives Rules' (UKCC 1998) confirming that it is the midwife who refers women with complications on to the medical practitioner as appropriate, the involvement by obstetricians in cases or potential rather than proven risk is blurring this line of demarcation between spheres of practice. The status of obstetrics, as the legitimate authority in relation to the risks associated with childbirth, escalates with the increasing prominence of the concept. Midwives, as the experts in low risk birth, are attributed

less status (and therefore responsibility and autonomy) as prestige and power are given to those who manage high risk situations.

Risk is an important concept in the current provision of maternity care and has a significant impact on the midwife's sphere of practice. The way that risk is managed is also an important consideration as it effects professional autonomy and control.

Risk Management

Nettleton (1997) reports that an analysis of the medical journals in Britain, the U.S.A. and Scandinavia found that the term 'risk' has reached 'epidemic' proportions, increasing significantly as it has in the midwifery literature. The number of 'risk articles' in the period 1967 to 1972 was around 1000; from 1986 to 1991, this had increased to over 80,000. 'Risk management' is an approach which has gained a high profile in all areas of medicine but most especially in obstetrics (where the biggest litigation cases tend to happen). It can be defined as 'the reduction of harm to the organisation, by the identification and, as far as possible, elimination of risk' (Clements 1995). Although this definition relates to the value of managing risk to the organisation, many authors believe there can be very sound reasons for participating in the approach in terms of individual benefit. O'Connor & Beard (1996) include the improvement of standards / practice, Smith & Mitchell (1996) highlight postnatal debriefing and Aslam (1999) alludes to reflective approaches, all laudable outcomes. However, the main emphasis in risk management is the avoidance of litigation (Dineen 1996) and therefore big payouts to dissatisfied parents. Indeed, NHS Trusts can access reduced insurance rates if they comply with CNST (Clinical Negligence Scheme for Trusts) standards which prove that they have an effective risk management structure in place.

The main negative aspects of risk management include care which is dictated by a risk management board, with little recognition of women's individuality, and the need for defensive practice, always having to be aware of the possibility of litigation if care does not conform strictly to guidelines. Midwives, who are currently writing about risk management, seem to focus on the positives so that they do not feel controlled or dominated by having to participate in a medically / legally driven initiative. One outcome of risk management approaches in maternity services is sets of protocols which direct care and are seen as leading to best practice by the members of the risk

management board. However these protocols may not be developed interprofessionally, so midwives may have little say in their content, and they are not always based on research evidence, often favouring the traditions of the consultant obstetricians, paediatricians or anaesthetists who have led in their formulation. One situation of a 'near miss' or an unfavourable outcome can lead to a change in practice in a unit in order to try and prevent such recurrences. This may have a negative impact on many women as caution may prevent choices being offered or supported if requested. The use of protocols (especially if they are not based on best available evidence but rather on consultant preference) undermines midwives' decision making and use of professional judgement in individual care situations. They can reduce the potential for autonomous practice in environments where autonomy is already very difficult to achieve.

Downe (1991) describes some frustration at experiencing the individual nature of the interpretation of normality versus risk. While working on a delivery suite, she contacted an obstetric registrar to refer a labouring woman as a result of determining that the fetal heart rate trace was abnormal. The registrar told her that, in fact, it was perfectly normal and that she should not worry. Very soon thereafter the registrars changed and, in another case with a very similar fetal heart rate trace, a different registrar decided that this was definitely abnormal requiring further investigation by fetal blood sampling. The women were similar, the labours were similar, the traces were similar, the midwife was the same; only the doctor was different, creating a completely different interpretation of the situation. It would seem that normal and risk may be in the eye of the beholder based on personal experience as well as external evidence. Risk management aims to reduce this individual interpretation through the development of protocols based on the lessons learned through 'near misses'. This sets up a controlling culture, part of the 'technocratic model' of childbirth which "functions as a powerful agent of social control, shaping and channelling individual values, beliefs and behaviours" (Davis-Floyd 1994:1125). The principle on which risk management is based, that of making practice 'safer', seems admirable. The effect of it, however, cannot be ignored; constant framing of experience through the 'risk' approach can set up a culture of fear and reduce individual choice.

Kirkham (1996:166) indicates the need for midwives to have knowledge in order to be able to ensure safety but suggests that this knowledge "needs to be experienced by the mother as a safety net rather than the ringmaster's whip. In giving support and exercising skill the midwife's role is an enabling one." This enabling role appears to be what women are requesting from maternity services rather than control or constrain as a result of the need to manage risk. Women appear to be asking to be able to take control of their childbirth experience, as is demonstrated in the government's 'Changing Childbirth' report (D.O.H. 1993), and are wanting midwives to have a belief in a woman's ability to give birth without intervention (Hutton 1994). This suggests that a move away from the interventionist approaches associated with contemporary obstetric led services is where midwifery should be going if consumer demand is to be met.

The Art of Midwifery

> Unlike the knowledge about the natural sciences, which may be controlled, tested, measured, and replicated, midwifery practice is concerned with humanity or 'unnatural sciences' which cannot be so controlled, because people are unpredictable, individual, have values, attitudes, emotions and feelings which are perceived and expressed in diverse ways and experienced in diverse contexts.

> Siddiqui 1994:419

The need and ability for midwives to respond to the woman's unique experience of giving birth suggests that there is an artistic element to midwifery practice. Siddiqui (1994) goes on to say that "to examine midwifery concerns from a cause and effect or reductionist outlook, may be to ignore the 'art' in favour of the 'science' and in doing so, to completely miss fundamental truths about midwifery knowledge". The essential belief here appears to be that, not only is there an artistic component to midwifery practice, but that it is, in fact, the element of prime significance. Kelly (1997) points out that the art of midwifery practice is often impeded by policies, organisational structures and the medicalisation of childbirth. She suggests that the 'conveyor belt' of the medical model (with its surveillance, monitoring, risk and management) can prevent supportive, meaningful and empathic relationships. This 'artistic' side to midwifery practice appears as a key concept in many authors' writing. The rest of this chapter will report the related concepts which are prevalent in the contemporary midwifery literature.

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What is Art?

Bates (1995) suggests that authentic midwifery practice is clearly an art and it is in the best interests of women that it remains so. Oakley (1989) likens the artistic or caring component of midwifery to love as opposed to technical expertise or science. It seems obvious that these writers are indicating that the interpersonal dimension of midwifery practice is the significant one, the essence of the role which makes midwifery unique. A mother who gave birth in Cambridge in 1987 is quoted to have said "I think that in a perfect world every mother should have what I had - a midwife's face that said 'look, we have performed a miracle together'" (Oakley 1989:220).

There is little in the midwifery literature to help us really understand just what authors are referring to in the concept of the 'art' of midwifery. Assumptions may be made of a consensus opinion as to what 'art' means. Page's recent textbook 'The New Midwifery: Science and Sensitivity in Practice' (Page 2000) highlights two dimensions but chooses not to use the word 'art'. In the book, the chapters are divided into two main groupings - those that refer to an understanding of physiology and evidence based practice and those covering subjects to do with care, human love and social support. The latter are those in the 'sensitivity' category.

Art can be defined as "a skill, especially human skill as opposed to nature; practical application of any science" (The Concise Oxford Dictionary 1982). Rose & Parker (1994) suggest that art is a skill or craft which is not instinctual but learned; it creates connotations of beauty and creativity. Harrison Barbet (1990) questions whether there are, in fact, any criteria which must be fulfilled for something to be considered as artistic or whether art may be simply a matter of subjective opinion. Basing the definition of art in the subjective places it in opposition to science which is held up as objective and 'true'. Using that as a starting point, this section will look at aspects of midwifery practice which are to do with the interaction between midwife and woman, those areas of practice which are to do with sensitive, subjective experience.

Relationship

It would appear that many of the concepts discussed in the literature relate to an important theme - that of the relationship between the mother and the midwife. Several

concepts contribute to that theme- 'good' or 'special' midwives, reciprocity and professional versus friend.

Good / special midwives

Berg et al (1996:11) suggest that "it should be the aim of each midwife to provide individualised care and to develop a close and co-operative relationship with each woman". McCrea & Crute (1991:184) undertook a study of the relationship between the midwife and client based on the belief that "some 'special relationship' is created between the midwife and client. This does not always happen, but when it does, it seems to have a most beneficial healing or therapeutic effect for clients." Page (1995:229), when discussing the 'new' breed of midwife necessary to improve maternity services, states "the new midwife is an experienced clinician who works in and through a relationship with the woman, and who cares effectively, knowing what benefit her actions and advice are likely to have for the woman and her baby, and offering care appropriate to the individuals concerned. This working in and through a relationship is pivotal to the midwife's practice."

Several authors refer to the characteristics of the midwives which contribute to positive relationships. Hutton (1994), having surveyed women's views about the midwives involved in their pregnancy, birth and early parenthood, found that the best memories these women had related to the type of relationship which had developed. The 'best' midwives were those who gave support, encouragement, explanations, progress reports and who consulted the woman about her wishes. The 'worst' were those who made careless remarks, casting doubt on the outcome of the pregnancy, who were insensitive and lacked co-operation and who gave conflicting advice. These comments indicate that midwives have an impact on the woman's experience which can be positive or negative depending on the effort put into developing a therapeutic relationship.

McCrea et al (1998) observed eleven midwives caring for fifteen women in labour. They concluded that these midwives fell into three categories - cold professional, warm professional and disorganised carer. The warm professional was felt to be most effective in supporting women as they provided information in a way which invited women to seek clarification without feeling that they were asking 'silly questions'. Their

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ability to relate in an open and caring way appeared important and helpful to women in labour.

Shields et al (1998) undertook a large randomised controlled trial of 1299 women in two categories: midwife managed (648) and care shared with doctors (651). Questionnaires from both the antenatal and postnatal periods were analysed and revealed that the midwife-managed group of women felt more positive about their relationships with staff, especially in terms of information transfer, choices, decisions and social support.

Wilcock et al (1997) reviewed the literature on obstetric patient satisfaction in North America over 25 years and found that issues relevant to the caring relationship featured in five of the eight most significant factors. Fraser (1999) confirmed similar factors in her longitudinal study of women's perceptions of midwifery care. She concluded that a trusting relationship and effective communication style were crucial to positive experiences. Women appear to benefit from having the midwife as a skilled companion (Page 1993) who acts as a guide and counsellor as well as a friend and known point of contact in the health care system.

Personal attributes or qualities are considered by many writers to determine the type of relationship which is likely to develop between mother and midwife. Some of these qualities include honesty (Demilew 1990, Troutt 1994), humility (Isherwood 1992), gentleness (Manning 1994), kindness (Wang 1995), empathy (Schott 1994) and an intuitive nature (Kitzinger 1988). In fact, Davis (1981) claims that the essence of midwifery is 'being humble' and 'paying attention' (to women). Leap and Hunter (1993) in their extensive interviews with handywomen / midwives practising in the early part of the twentieth century in Britain quote some basic attributes which these midwives believed to be important. These include common sense, understanding, ability to get on with people, kindness, patience, the right attitude (have to be the mother's friend), cheerfulness, tact and sympathy. The picture of the midwife created through the words of all of these authors is one who is nice to the women she cares for and who is willing to develop a friendly and understanding relationship with them.

Reciprocity

Fleming (1998) defines the concept of 'reciprocity' in the midwife / woman relationship, an interdependence including attending (paying attention to) and prescencing (being there). She undertook her study in New Zealand where the partnership model between women and midwives had been established and supported by the New Zealand College of Midwives since the 1990 legislation, which guaranteed the right of midwives to practice independently of the medical profession. The logo of the College is "Midwives need women need midwives" indicating the interdependent and close relationship aimed for by those setting the scene for the new model of midwifery practice offered by the change in law (Bryar 1995). Fleming found that there was difficulty in achieving the ideals of the College as true partnership requires both parties to engage as equals. Despite the midwives in the study feeling that they were truly sharing the experience, the women continued to feel that the midwives were the 'medical' experts. This did not take away from the experience for the women in this study but the findings indicate the challenge for midwives to reflect personally on the way they present themselves as well as acknowledging what women actually want in the relationship.

Professional versus Friend

Walsh's (1999) ethnographic study of women's experiences of caseload midwifery found that the relationship was the primary theme; the midwife's attitude and behaviour helped in the development of a 'friendship' for the duration of the care period, significantly contributing to a positive experience. The dimensions of the midwife - mother relationship are explored by a number of authors in Mavis Kirkham's edited text on the subject (Kirkham 2000a). In the chapters of that book, several key aspects of the relationship are discussed including: the midwife acting as a 'professional servant' (Cronk 2000), the need to move beyond professionalism to a more personal relationship in order to truly relate effectively with women (Wilkins 2000) and the crucial element of trust within the relationship (Anderson 2000b).

Edwards (2000) found in her research with women in Scotland seeking homebirths, which was also reported in Kirkham's text, that if a bond was formed between midwife and woman, the midwife was seen by these women as 'being on their side', having the qualities of a friend and competence of a professional.

A theme running through Kirkham's book is the potential tension for the midwife as the mediator between the individual woman and the organisation in which midwifery care is delivered, as was discussed in the section on 'bureaucracy' in chapter two (page 39). The balance of meeting the needs of the employer and the profession alongside those of the woman is identified as a key challenge, especially when midwives are often in a relatively powerless position in large organisations. The dominant ideology of the institution is likely to be one of effective use of resources and "when the service is seen in such industrial terms, care becomes fragmented and conveyor belt-like, and little attention is given to developing relationships between midwives and mothers" (Kirkham 2000b:233). It seems likely that the organisational culture will have a profound impact on the midwife - mother relationship, possibly of far more significance than the personal attributes of the midwife. It may be very difficult to respond to women appropriately, supportively and in a friendly way in a system where there is no opportunity to get to know the woman over a period of time, nor is there any priority given to the importance of that opportunity in the face of efficiency within limited resources.

It would seem that relationship is definitely a key theme in midwifery although the current prevalent pattern and priorities of care present challenges for the development of effective and fulfilling relationships. Studies discussed here have shown that women value a positive relationship with the midwife; one important dimension of developing a relationship is in the ability to communicate.

<u>Communication</u>

Another important concept within the theme of relationship is communication. This is an important element in the building of a relationship; communication skills can significantly contribute to a positive woman / midwife relationship. The ability to listen and share without blocking women's feedback contribute to the concept of communication.

Listening

> When I ask you to listen to me and you start giving
> advice you have not done what I asked ....

> When you do something for me that I can and need
> to do for myself, you contribute to my fears and
> weakness ....
> When I ask you to listen to me and you begin to
> tell me why I should not feel that way, you are
> trampling on my feelings ....
> So please listen and just hear me. And if you want
> to talk, wait a minute for your turn, and I will listen to you.
>   Anonymous (cited in Kenyon 1991:98)

In Kenyon's research on counselling in midwifery (1991), it was identified that there is a growing awareness of the need for counselling / communication skills training for midwives. She pointed out that although midwives normally give much advice to the women they care for, less than 10% of the midwives responses demonstrated an acknowledgement of the mother's message. Her conclusions suggest that a move towards an empathic approach to care, in which midwives have the ability and desire to listen, would improve the effectiveness of communication in the midwife - woman relationship.

This concept of listening is reinforced by the research undertaken by Berg et al (1996). One woman interviewed said "This was the first time I felt that someone listened to me and not just to the baby's heartbeat". The women in this study also felt that the encouragement by the midwife to listen to their own innermost feelings was a valuable source of support. Butler & Jackson (1998) point out the distinction between hearing (ability to receive sounds) and listening (receiving the sounds and interpreting them), identifying barriers to listening which can interfere with effective communication. In addition to environmental factors, attitudes, values, past experiences and poorly developed skills can all get in the way of really being able to hear what women are saying.

Blocking

Listening is one of many aspects of communication highlighted in the research conducted by Kirkham (1989) but something which midwives do not always do. Her study of the information which midwives give to women in labour illustrates the fact that women have an intense need for information but midwives do not always help to meet this need. Despite the virtually unanimous agreement by the midwives in this study that women want and deserve information, a number of issues constrained their

communication. These included the social class (and therefore perceived ability to understand) of the women, hospital policies and the inexperience of the practitioner. Midwives employed tactics which block effective communication, such as routine patter and closed comments, which prevented contact with the woman's fears or wishes. There were attempts to reassure the women but these were rarely based on clear explanations of what was going on in the labour; the midwives appeared to try to minimise the situation in order to prevent worrying rather than providing the information which would enable women to understand the implications of it.

This 'blocking' was also demonstrated in Methven's (1990) work on the antenatal booking interview. She found midwives routinely used closed questions, controlling the flow of conversation in so doing. This may show ineffective communication skills in the midwife or, in contrast, very effective skills in keeping the interview concise at a period when time available for each woman in a busy antenatal clinic was constrained. MacIntyre's work (1982) illustrated the way women could feel 'fobbed off' by routinised use of language. In the current NHS climate, this may well be a coping mechanism for busy, stressed midwives to be able to get through the work. Adams (1987) found in her study that women preferred the educating / encouraging midwives' communication style to that of direction. The Informed Choice study (Kirkham & Stapleton 2001) highlighted how the system creates a 'right' choice for women, one that supports the medical norm (as discussed in the section on Risk). The communication style may not appear directive but it is very likely that the woman will be steered in her decisions by what is presented to her as options.

Sharing
Hughes (1988) claims that midwifery practice is based on the two-way exchange of information. Davis (1994) believes that women need to be well informed about the range, quality and costs of services available to them as part of their decision-making process. She continues to say that a change in the relationship between consumers and professionals must take place from one of control over professional knowledge to one of partnership where knowledge and decision-making is shared. Symon (1997) supports the need for midwives to be able to clearly explain complex issues to women in order to help them make choices and reduce litigation. In all of the 'Confidential

Enquiry into Stillbirth and Death in Infancy' reports produced, failure to communicate effectively has been implicated as a major contributor to suboptimal care.

From the authors cited, it can be seen that the ideal communication between midwife and woman is more than just information giving. It includes listening, empathising, encouraging, sharing and supporting. Kirkham (1993:15) suggests that "good communication is two way and likely to be aided by relationships of equality. We must, therefore, aim to give care in such a way that women and midwives work in equal partnership.... (and) we should avoid ways of communicating which reinforce power differences." The opportunity to develop a continuing relationship over the childbearing period can be helpful in providing opportunities for women and midwives to communicate effectively and to share in decision making.

Continuity of Care and Carer

The issue of continuity is a 'hot topic' in the midwifery literature, recognising that in the past a continuity arrangement between woman and midwife would have been the norm (for example Allison 1994). In order to provide a concise review of the issues raised and research undertaken, this section will succinctly address the main points under debate as they are significant concepts being discussed in the literature.

Teams

Team midwifery was first described as an approach to maternity care by Flint et al (1988). In their pilot project, a small team of midwives provided continuity of care through pregnancy, birth and the puerperium to a defined group of low risk women. The results of the evaluation of the project were very positive; both women and midwives found this way of providing care substantially more satisfying than the fragmented approach common in the British maternity services at the time. The opportunity to get to 'know-your-midwife' early in pregnancy was valued by women to such an extent that many other services piloted similar approaches leading to increased client satisfaction in general.

Since that time, two main approaches to practice - team midwifery and caseload practice - have become increasingly (but not uniformly or even predominantly) prevalent. The 'Changing Childbirth' Report (DOH 1993) aimed to embed a scheme of

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continuity throughout the maternity services in the NHS (unfortunately this was promoted as good practice but not financed accordingly). The main difference in the two schemes relate to the notion of an individual carer (caseload) as opposed to a consistent philosophy of care provided by a small number of midwives (teams).

Defining Continuity

Lee (1997) provides an indepth exploration of the differing interpretations of continuity, identifying that there are notions of: providing individualised care; minimising the numbers of carers a woman comes into contact within the maternity service; following the woman's journey through pregnancy, birth and puerperium; building a relationship of trust; a philosophy of consistency of policies, practices and individualised care plans. She chooses to define 'continuity of caring' as processes of care and 'continuity of carer' as the continuity of personnel within the structures of care. The literature describes many of each scheme, several having been researched and evaluated.

The Benefits of Continuity

Two systematic reviews have been undertaken on continuity schemes. Hodnett (2001) examined two large trials which compared outcomes for women in two groups, those receiving continuity of care during pregnancy, birth and puerperium versus those receiving 'usual' care by multiple care givers. The conclusions of the review were that continuity of care shows beneficial effects (both physical and psychological) although the reviewer recognises that it is not clear whether this is due to the continuity or to midwifery led care. Waldenstrom & Turnbull (1998) systematically reviewed seven randomised controlled trials of alternative maternity services characterised by continuity of midwifery care. They also found beneficial effects in terms of lower intervention rates in the continuity of midwifery group.

These reviews provide evidence of beneficial outcomes in continuity of care (i.e. team) schemes. In addition, Page, McCourt et al (Page et al 2001, 1999, McCourt & Page 1996), the North Staffordshire Changing Childbirth Research Team (2000), Walsh (1999) and Walker (1999) all found positive results in continuity of carer (caseload) schemes. However, questions have been raised by Green et al (1998) following their structured review of studies which looked at these new ways of organising maternity services (both continuity of care and carer). This review highlights the lack of clear

definitions and descriptions in the various continuity schemes having been studied. They conclude that the organisation is less important to women than the competence, caring and communication skills of caregivers. The questions in response seem to be 'are these not related in practice?' and 'why shouldn't both of these be available to women?'- competent, caring midwives with good communication skills within a scheme of continuity.

Criticisms of Continuity of Carer

There is a common criticism of caseload schemes in relation to the personal commitment required by the midwife to be on call frequently for the women in her caseload. Farquhar et al (2000) describe the problems encountered with achieving good antenatal and postnatal continuity if midwives are also providing intrapartum support. If midwives are trying to be available to all of the women in their caseload and provide continuity throughout, it would seem possible that this could lead to stress and burnout. However, Sandall (1999) undertook a survey of a 5% random sample of midwives in England and measured occupational burnout. She found that midwives in teams did experience high levels of burnout. In contrast she confirmed, by a multiple site case study, that those holding an individual caseload (in which they had control over their workload) were found to experience less burnout and a greater sense of personal achievement than those in teams (Sandall 1997).

The opportunity to have control over one's own workload, to practice autonomously in partnership with women, appears to be empowering and satisfying for midwives. The evidence would seem to suggest that women also have a more positive experience when cared for by midwives in a scheme of continuity. Continuity of care and carer are two important concepts within the theme of relationship.

<u>Choice and Control</u>

The other two key features of the 'Changing Childbirth' Report (DOH 1993), in addition to that of continuity, are choice and control. The aim of these 'three C's' is to create a woman-centred maternity service which truly meets individual need. Many authors are currently discussing these issues of choice (primarily in respect of place of birth and main caregiver) and control, as the shift required within services and individual practitioners is substantial in order to meet the ideal.

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Sharing Control

Cameron (1996) identifies the need for a partnership approach to care where the decision making is shared between women and health professionals. This sharing approach to care suggests a redress in the power or control of childbirth. As was suggested earlier in this paper, the medicalisation of childbirth has largely removed women's ability to play an active role in deciding where, when and how to give birth. The Cumberlege Report (DOH 1993) has set an agenda for empowering women, or giving them control over the issues they believe to be important, about their childbirth experience.

Empowerment is a transactional concept (Gibson 1991); that is, it involves the powerless taking control as well as the powerful releasing it. This construct may imply that power is finite with an absolute quantity to be apportioned. Although this is not the case, unless those in power are willing to relinquish control, there is a profound challenge for the less powerful to achieve autonomy and authority.

In the literature, women are clearly identifying the advantages of feeling in control. Bramadat (1993) found that even fifteen to twenty years after giving birth, women still had vivid memories of the experience. "Those with high satisfaction scores could be distinguished from those with low scores by their feelings of having accomplished something important, being in control, having an experience that contributed to their self confidence and self esteem" (Bramadat 1993:27). Cooke (1995) in her interviews with women who had experienced continuity of carer during their pregnancy and birth experience, found that making decisions in pregnancy and childbirth enhances a woman's feelings of control and self esteem. The burgeoning profession of midwifery in Canada (where until recently virtually all births were conducted by doctors in a hospital setting) is based on a client empowered model where women are encouraged to actively participate in their care and make informed choices (Farnsworth & Saxell 1993). Similarly the partnership model which has been adopted in New Zealand, referred to earlier (Donley 1997), aims for a 'woman who is in control of labour and actively gives birth as she will be empowered, filled with a sense of well being and faith in herself'.

Information for Control

An essential prerequisite for women being able to take control of their experience is having sufficient knowledge and understanding of both the system they are in and the process they are undergoing. Therefore it appears to be fundamental for midwives to be able to provide the information which women require to make appropriate choices. "Women who are not informed or who are given inadequate information are unable to be active participants during labour and therefore respond with fear and passivity" (McKay & Yager Smith 1993:140). This belief is supported by Lovell (1996:268) who suggests that "the prerequisite for being in control is having the power to make decisions; and the prerequisite for decision-making is having full access to information". Both accessing and using this information must take place in a context. In the maternity services, women are largely given information which relates to the expected norm (as discussed in the sections on Communication and Risk). There is a challenge in seeking out alternative perspectives; consumer groups, like the National Childbirth Trust, have played important roles in helping to present women with information and evidence about appropriate alternatives to the norm (Newburn & Hutton 1996). Women can be considered as deviant if they are not happy to tow the party line of the maternity unit (i.e. make the 'right' choices) and group support through these organisations can provide confidence and a more powerful challenge to custom and practice.

Confidence can come through positive experiences of birth even when things do not go as planned. Through a phenomenological study of women's experiences of complicated childbirth, Berg & Dahlberg (1998) concluded that recognition and affirmation are crucial for the development of confidence. Women were found to need 'real' dialogue with carers to ensure understanding and therefore increase their sense of control. If they did not have their existence acknowledged effectively, it led to the negative feelings of guilt, fear, shame and anger.

Lavender et al (2000) undertook a longitudinal study with 80 women in both the antenatal and postnatal periods. They explored the timing, amount, content and format of information giving through the childbirth period and found that women, generally, did not receive the information to meet their individual needs as it was often given at inappropriate times and may have been unrealistic in their context. This study identifies

key issues for supporting women's needs for information as tools to help them feel in control.

Levy's grounded theory study (1999) identified a core category in the processes involved when women make informed choices in pregnancy. 'Maintaining equilibrium' included the seeking and dealing with information to balance the interests of the woman herself, the baby, her partner and significant others. The woman, having acquired information, needs to regulate it, contextualise it and then take action to help maintain her equilibrium. In order to be able to support the complex skills required to undertake these processes, a midwife needs an awareness of her / his own biases and a sensitivity to the woman's cues.

Language / Discourse

Another relevant issue in the discussion of women's access to information, in order to take control, relates to the language used by health professionals. The medicalisation of birth (discussed earlier) has led to the creation of a distinct discourse which is often inaccessible to women. There appear to be two main aspects for consideration: a patriarchal approach to women through the language used and the incomprehensibility of the terminology. Leap (1992) cites a variety of examples of the patter used by midwives around the time of birth which put women in a relatively powerless position. In many cases, the choice of words used places the midwife and / or doctor in the centre of the birth experience ('I delivered Mrs. X', 'I think I controlled the pain well'). The woman becomes the passive recipient of midwifery or medical action rather than the person actively birthing a baby.

The medical terminology used in pregnancy and labour may also exclude the woman from being in control of the situation. Bombarded with terms such as gestation, trimester, fundal height, biparietal diameter and cephalic presentation, even from the first antenatal appointment, women may feel powerless to control an experience which they cannot understand. Hewison (1993) in a discussion of the discourses of childbirth, suggests that the social construction of the whole birth experience is framed by the terminology used in and around it. Scambler (1987) states that "it is quite inappropriate that so many of the pivotal decisions surrounding the bringing of a baby into the world

have been redefined as technical and usurped by physicians in their role as experts or agents of formal knowledge".

The move to client held notes and negotiated parent education classes are two ways in which the negative effects of language are being mediated by midwives. However these means may not be sufficient to empower women unless there is a fundamental shift in the underlying beliefs by health professionals as to who should be in charge of the birth experience. Empowerment of women requires a release of control by the professional group who has it. The historical review and issues discussed earlier in this chapter have demonstrated that the control of childbirth by medicine appears to be on the increase rather than the decrease, with midwifery continuing to be in a relatively powerless position. There is a need to redress the balance in the maternity services but this is a considerable challenge with many implications.

Choice and control are part of the rhetoric of current policy in maternity care; control is clearly an important concept in midwifery. The ideal of sharing that control to empower women is one which is not always upheld. Lack of information or inaccessible language can interfere with women being able to take control of their childbirth experience. However, midwives who also do not feel in control may find it challenging to support this aim for the women they are supporting, as was widely discussed in chapter two. Despite this, the concepts of choice and control are prevalent in the midwifery literature as an ideal if not real issue in current practice.

Integrating the Concepts

Having reviewed a large body of literature relating to concepts of importance to midwifery and structuring the review under the headings of 'science' and 'art' (as these are used commonly in that literature), it would seem to me that possibly more accurate titles would relate to the contrasting models of health discussed on page 60 - medical and social. I would define the concepts of evidence based practice, risk and risk management as medical and the key theme of relationship with the concepts of communication, continuity, choice and control as essentially social. This review highlights the priority for many midwifery writers on the social dimension of childbirth, with the medical perspective in the literature having increased significantly through the six years of this project.

The changes taking place in and around childbirth, with technology and intervention becoming more common each year, pose real challenges for midwives wanting to prioritise the social dimensions of care for women. These social dimensions are clearly important to women as has been demonstrated in this review. Cowie & Floyd (1998) suggest that the concept of 'being with woman' (a concept which is implicit in much of the literature but not made explicit by many) is harder to achieve with technological advances. The heavy reliance on mechanical means of monitoring the fetal and maternal condition in labour may lead to midwives who are de-skilled, losing the ability to be 'in-tune' with a woman and aware of the significance of her behaviour.

The relative lack of reference to midwifery knowledge of physiology in the literature appears to be a gap in key concepts which are important to the practice of being 'with women'. Physiology as defined by medicine seems to be the accepted as 'scientific' and considered as authoritative knowledge. The need to make explicit midwives' embedded knowledge would seem a priority in order to prevent this knowledge being lost as technological birth increases in prevalence and midwives have less experience of non-interventionist birth. Similarly the lack of definition and discussion about normality in the literature may create tensions at a time when cases of risk (or the potential of complication rather than the diagnosis of a condition) are being considered as medical rather than midwifery ones.

McFarlane & Downe (1999) describe the 'focus of midwifery principle' based on research with midwives about the nature of midwifery. The dichotomy of 'supporting the parent' versus 'managing a clinical event' remained a strong reality dividing the midwives interviewed in their study. This research highlights the two perspectives and the balancing act which midwives need to undertake to meet the needs of the woman and those of the organisation (which is largely medically dominated in the NHS). Despite the need to achieve this balance, the literature has little discussion about effective ways in which midwives can work with other professionals to the best advantage of women.

Page (1998) claims that the 'art' and 'science' of midwifery come together in evidence based practice, which arose from a need to challenge the routines of a system that did

not serve the needs of individuals. She proposes that evidence based practice alters the balance of power to include women in the decision making, curtailing the clinical freedom of practitioners who base care on custom and tradition. The art of evidence based practice is all about balancing and interpreting a wide variety of sources of evidence, effectively communicating this to women, listening to their needs, supporting their choices and then helping them to have the experience of choice. Achieving this balance effectively requires knowledge, self esteem, confidence, skill and good working relations with colleagues. The position of midwives in the current hierarchy of care may make it difficult for them to manage this challenge.

Summary

This chapter has considered the role of theory and explored many of the significant concepts within midwifery in Britain in the late twentieth century, having previously reviewed the historical developments and their impact on the occupation in chapter two. Midwifery continues to be a significant occupation, playing an important supportive role for childbearing women. However its position is relatively powerless in the medical, management and nursing hierarchies in the National Health Service. The current emphasis on safe practice, reduction of risk and evidence based practice has led to protocol-driven services which do not always support the needs of individual women using them. The midwife requires skills to be able to mediate the tensions between meeting the needs of the woman and the organisation and the literature suggests that these may often be at odds. This balance may be very difficult to maintain when midwives themselves do not feel in a powerful position in the system of care.

Many authors currently writing in the midwifery press appear to be focussing substantially on the interpersonal or social elements of midwifery, the skills which can help to provide support to women effectively, regardless of the context of care. I suggest that the word 'relationship' would appear to be the pivot in the discussion, as the other elements (communication, continuity of care and carer, choice and control) all impact on the woman / midwife relationship. The development of a relationship with women is crucial in providing effective support and can be the means by which women achieve a satisfying birth experience in a large, impersonal maternity service.

This chapter has also considered many of the implicit values which are learned by students becoming midwives and identified some gaps in explicit midwifery knowledge. The next chapter will review additional literature, that on how learning takes place, in order to integrate the product with the process of learning to be a midwife.

Chapter Four

Learning

Introduction

Having identified significant concepts from the literature relating to the practice of midwifery (the 'what'), this chapter will explore issues pertinent to the process of learning that practice (the 'how'). The expectations of programmes of midwifery education, set by regulating bodies in Europe and the U.K., and current national drivers will be reviewed initially. The process and some theories of learning will then be discussed to set a context for the review of evidence in relation to midwifery education. As the literature on theories of learning covers an enormous range, the first section of this chapter will discuss selected concepts particularly relevant to the learning of a practice based occupation.

The two subsequent sections present the findings from a structured review of research undertaken in both midwifery and nursing education, primarily but not exclusively in Britain, over the past ten to fifteen years (see appendix 2 for synopsis of studies; my thanks to Sarah Beake who collated the findings from these studies so I could analyse and use them in this review). The review was conducted using a variety of search tools - MIDIRS, ENB Health Care, Ovid and BIDS IBSS databases were all accessed. The key word 'learning' elicited several hundred sources on each database; this was refined to 'practice' and 'learning' which also generated a large, but somewhat more manageable, number of articles. In addition, 'student midwives', 'socialisation', 'professionalisation' and 'apprenticeship' were entered. The abstracts for all of the articles were examined to determine which were based on primary research. All of the midwifery educational research as well as relevant nursing research has been used to inform this discussion.

Themes in this research have been identified and the findings of the review will be presented under the headings 'learning the trade' and 'learning to behave'. It is recognised that these divisions are not definitive and there are issues which cross over the two. However, the framework is one that is helpful to structure the findings of the review in terms of their key significance for learning to be a midwife, as the research

generally fits well into either one of these two categories. The exploration of this evidence is a significant part of the preparation necessary to underpin a strategy for learning to be a midwife.

Section One - Midwifery and Learning
Expectations of Programmes of Midwifery Education

The expectations or outcomes of programmes of education leading to registration as a midwife in Britain were defined by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting - UKCC (now been superseded by the Nursing and Midwifery Council - NMC). At the end of the course, the student will achieve the following outcomes:

- the appreciation of the influence of social, political, and cultural factors in relation to health care and advising on the promotion of health
- the recognition of common factors which contribute to and those which adversely affect the physical, emotional, and social well-being of the mother and baby and the taking of appropriate action
- the ability to assess, plan, implement and evaluate care within the sphere of practice of a midwife to meet the physical, emotional, social, spiritual and educational needs of the mother and baby and the family
- the ability to take action on her own responsibility, including the initiation of the action of other disciplines, and to seek assistance when required
- the ability to interpret and undertake care prescribed by a registered medical practitioner
- the use of appropriate and effective communication skills with mothers and their families, with colleagues and with those in other disciplines
- the use of relevant literature and research to inform the practice of midwifery
- the ability to function effectively in a multi-professional team with an understanding of the role of all members of the team
- an understanding of the requirements of legislation relevant to the practice of midwifery
- an understanding of the ethical issues relating to midwifery practice and the responsibilities which these impose on the midwife's professional practice
- the assignment by the midwife of appropriate duties to others and the supervision and monitoring of such duties

UKCC 1998

In addition, the European Union makes explicit its expectations of all member states through its Midwives Directives.

"Member states shall ensure that midwives are at least entitled to take up and pursue the following activities:

1. to provide sound family planning information and advice

2. to diagnose pregnancies and monitor normal pregnancies; to carry out examinations necessary for the monitoring of the development of normal pregnancies

3. to prescribe or advise of the examination necessary for the earliest possible diagnosis of pregnancies at risk

4. to provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition

5. to care for and assist the mother during labour and to monitor the condition of the fetus in utero by the appropriate clinical and technical means

6. to conduct spontaneous deliveries, including where required an episiotomy, and in urgent cases a breech delivery

7. to recognise the warning signs of abnormality in the mother and infant which necessitate referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measures in the doctor's absence, in particular the manual removal of the placenta, possibly followed by manual examination of the uterus*

8. to examine and care for the newborn infant; to take initiatives which are necessary in case of need and to carry out where necessary immediate resuscitation

9. to care for and monitor progress of the mother in the postnatal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the newborn infant

10. to carry out the treatment prescribed by a doctor

11. to maintain all necessary records

*In present day practice in the United Kingdom, the midwife should not find herself in a position where medical aid is not available for such grave emergency measures as manual removal of the placenta"
European Community Midwives Directive 80 / 155 / EEC Article 4)

These two sources have been complemented in the past with additional guidance from the English National Board for Nursing, Midwifery and Health Visiting which expanded on these expectations with more complete descriptions of the content of the programmes. For example, the competencies in practice identified in the Midwives Rules are extended to include issues relevant to the ethical nature of practice, respecting diversity, working together with others, basing practice on evidence, using information technology and auditing care (ENB 2001).

Part of the research project undertaken by Fraser, Murphy & Worth-Butler (1997) reviewed the curriculum documentation from twenty three long pre registration midwifery programmes in order to determine their effectiveness. This work helps us to understand whether the centrally dictated expectations are, in fact, embedded in the programmes of education currently offered in England. A synopsis of the outcomes of the programmes they reviewed identified three key themes which featured in all of the courses and identified them as:

- the professional / friend approach (including issues of midwifery legislation, attitudes and commitment, reflective practice, research based care, being autonomous and accountable, confidence, lifelong learning skills, working in a team)
- individualised approach (including issues of woman-centred care, needs - meeting approach, assessing / planning / implementing / evaluating, holistic approach, childbirth as normal and at risk as special cases)
- clinical competence (including issues of safety, competence; skills - clinical, managing, teaching, education, counselling, researching and client advocacy; sound, research-based knowledge base and the ability to apply it to practice).

This analysis indicates that the priorities defined by the European Community and the UKCC do appear in midwifery curricula generally. Fraser et al's project (Fraser, Murphy & Worth-Butler 1997) however did demonstrate a fair diversity of ways in which these outcomes were expected to be met. This work will be discussed further later in this chapter.

The Delivery of Midwifery Education

With so much guidance prescribed centrally, it would seem quite clear as to what a midwife needs to know in order to be able to practice competently. However there are challenges in organising this learning to ensure a consistency of output from programmes of education. Currently midwifery education lies in universities in Britain, with fifty percent of the learning taking place in the classroom and / or library and fifty percent taking place in the practice environment. The learning which takes place in either environment is generally facilitated by different staff. In the classroom, midwifery lecturers (who may or may not be currently practising midwifery) help students to gain the knowledge necessary to underpin safe and competent practice. This knowledge is

largely based on the UKCC / EC / ENB guidance presented earlier. Teaching and learning methods in the classroom are increasingly becoming student-centred and interactive so students can participate in informed discussion about midwifery practice. Often scenarios or case studies are used to help relate the underpinning knowledge to practice explicitly. In addition, skills laboratories are often used to help students gain confidence in basic caring skills before going into the real life situation in practice. In my experience of midwifery education over thirteen years, this fifty percent of the programme is normally well organised, controllable and largely predictable.

In contrast, the part of the programme experienced in practice is much less predictable. Students are generally assigned to a mentor, or qualified midwife with appropriate experience and basic teaching skills, to facilitate learning in practice. This may be a long term relationship (for the entire period in which the student remains in that area of practice, possibly weeks or months) or it may be on a daily or weekly basis depending on the staffing levels and shift patterns of the qualified staff. The role of the mentor is both to teach students and to provide moral support or pastoral care which will help them deal with the reality of practice. The main functions of the mentor include: to inspire the individual, to invest in her / his development and to support her / him emotionally with reassurance to develop confidence (Darling 1984). Practice mentors are often prepared for that role by undertaking a short post qualifying course on teaching and assessing in practice, which gives them basic skills to support learning. However this is not always the case; the turnover rate of staff in a maternity service may mean that there are a number of midwives who have not undergone any preparation. Even if they have had some basic training, midwives do not always enjoy being mentors so may not invest any substantial energy in helping students to learn, despite this role normally being part of the job description. In addition, many maternity units are poorly staffed with qualified midwives and the pace of work can be quite frantic. The priority in a very busy environment will normally be to provide the very best care to the woman possible, with student learning taking a lesser place. The learning which takes place in practice cannot be organised in advance with any degree of certainty due to the unpredictable nature of childbirth. Therefore the two halves of the programme of education are often quite different and do not always feel integrated to the student (McCourt & Thomas 2001).

There is a mechanism in place in many universities to help reduce this discrepancy. Midwifery lecturers, who are employed to teach on programmes funded by Workforce Development Confederations, are expected to spend twenty percent of their available teaching time in the practice environment. Effectively that means that a lecturer visits an area in practice to which she / he 'links' on a day per week basis. The activity undertaken in that time is diverse and largely agreed between the university and practice managers. The purpose of the 'link' is to help prepare and support mentors, to audit the quality of the learning environment in practice, to support practice development initiatives from an educational perspective, to directly support student learning (i.e. undertake seminars in practice or work side by side with students) and to maintain personal competence in practice. Despite this appearing to be an effective way to enhance integration between the university and practice, in reality students do not always appear to feel the benefit of this arrangement. The pressure on lecturers within the university (teaching, programme implementation and research demands) may be such that they do not always manage to meet this obligation. They themselves may feel inhibited about actually undertaking practice if they have been away from it on a regular basis for any period of time. Even if they do manage regular attendance in practice, lecturers may not appear visible to the students as a result of lack of coordination between visits and the students' shift patterns.

This context is an important consideration in determining a strategy for the education of midwives. Despite there being lists of content to be offered in programmes of education, the philosophy, values and priorities within the practice of midwifery will be communicated alongside the formal, taught curriculum. This 'hidden curriculum' (Jarvis 1985) is likely to be as, if not more, important in determining the type of midwives who exit the pre registration programme; the student will have experience of the 'hidden curriculum' both in practice and in the classroom. Many of the issues discussed in the previous chapters, which reviewed both the history of and current literature in midwifery, are included in the content of midwifery course syllabi but not all of them are listed in the activities defined by the WHO or UKCC. This allows for a diverse approach to programme development and delivery which will suit the local environment and resources; however, it may reduce the consistency of preparation both for and in practice and may lead to midwives with differing values from different areas or

courses. A clearer consensus on the less explicit components of the programme may benefit both students and women in their care.

With this description of the common current pattern of midwifery programme delivery in Britain established, some theories of learning will be discussed to consider their significance to the midwifery context. The three theories, out of many possibles, have been selected for discussion in this chapter as all relate to the education of midwifery students. The choice of which theories to include in this discussion was based on a number of factors. As an educationalist, I am very familiar with contemporary educational literature and interest; from my reading, I feel that all three are considered as important in current research and discussion. I checked out my assumptions about the most relevant theories to include with the Head of the Centre for Learning and Teaching at the university where I am employed to ensure she also supported my selection. Earlier theories of learning (for example, behaviourist approaches – Watson, Pavlov, Thorndike and Skinner; social learning theory – Bandura; assimilation theory – Ausubel; discovery learning – Bruner; theories of teaching – Dewey) are not to be dismissed as many provide the underpinning of contemporary understandings about the way people learn. However, they will not be explicitly involved in the following discussion as they are not currently reflected substantially in the literature around nursing and midwifery education.

Adult Learning

The distinct elements of adult learning became a focus for educational theorists in the early twentieth century. Prior to its inclusion in the study of learning, earlier theorists largely focussed on learning in animals and children. Conditioning or stimulus-response as a means to learning (for example by Pavlov, Guthrie, Skinner and Thorndike) or cognitive theories involving insight or understanding as key (for example by Piaget, Bruner, Dewey, Koffka and Kohler), emanating from the school of experimental psychology, were prevalent from the middle of the nineteenth century (Knowles 1978). In contrast, Lindeman in the 1920's identified that adults are thinking beings, with valuable experience; they benefit from teachers who enable exchange and interaction, with a sharing of authority between the teacher and student (Knowles 1978). Several authorities developed the theory considerably in the latter part of the twentieth century. Two include Knowles, referred to as the 'father of andragogy' (or

adult learning) (Knowles, Holton & Swanson 1998) and Carl Rogers, a humanist psychologist who believed in non-prescriptive freedom in learning (Rogers 1969). The literature in this area is vast; its relevance to the discussion of midwifery education at this time is twofold: students of midwifery are adults who bring varying backgrounds to their studies, and teachers of midwifery are currently prepared for their roles with the principles of adult education as the accepted theoretical basis to learning.

Therefore, one would expect that students of midwifery would be taught in ways which reflect these elements as defined by Knowles (1984):
    *setting the climate for learning
    *involving learners in mutual planning
    *involving learners in the diagnosis of their learning needs
    *involving learners in the formulation of their objectives
    *involving learners in the design of learning plans
    *helping learners to carry out their learning plans
    *involving learners in evaluating their learning

There is a tension between this student-centred, self directed approach to learning and the very prescriptive nature of statutory regulation, however. With the outcomes of the programme quite precisely defined in order to ensure safe practice, the student cannot decide their individual objectives unless they are closely aligned to professional requirements. Current curricula are often divided into the content and the process; the content is prescribed but there is some freedom in the method by which the learning is achieved. Fraser et al (1997) found in their study, described earlier, that the content and outcomes were quite closely related to the UKCC outcomes but that a variety of teaching and learning methods were used to recognise the differences in the ways which students learn. Many of these methods were self directed (diaries, journals, reading weeks) and interactive (seminars, tutorials, workshops, placements and projects), although they all included more didactic approaches like lectures as well. All programmes set out student-centredness as one of the ideals, with the aim of achieving personal development and awareness as well as high academic and professional standards. The researchers found that Knowles' approach of adult learning was implemented in some way in all programmes, commonly through the use of learning contracts or negotiated projects (Fraser et al 1997). However there was

also recognition that there are differences in students' learning styles so a diversity of teaching and learning methods were used in hopes "that by using a variety of teaching methods, some match to learning style will occur, some of the time" (Fraser et al 1997:34). So, although the concept of adult learning was recognised and some attempt made to use student-centred approaches to learning, there was little evidence that students themselves would be encouraged to take responsibility for deciding on the best way to learn given the context, content and goal of a particular part of the curriculum. Adult learning appeared to be defined by the curriculum developers as opposed to by the adult students in the programmes studied.

Adult learning, therefore, is part of the back drop of contemporary midwifery education in the Britain. Students of midwifery are considered as adults (at least in principle) and are actively engaged in their learning in some aspects of the curriculum, in an attempt to meet the needs of students with differing learning styles. The most significant part of that active learning may take place in their practice experience, that fifty percent of the programme which is situated in practice.

Situated Learning

Lave & Wenger (1991) introduced a theory related to learning referred to as 'situated learning'; it is considered to be a radical departure from traditional ways of conceiving learning and the development of knowledge (Tennant 1997). Their basic premise is that context is crucial in the development of knowledge, with learners participating in 'communities of practice' through 'legitimate peripheral participation' (Lave & Wenger 1991). They do not consider their concept as a theory of learning as such, but as "an analytical viewpoint on learning, a way of understanding learning" (Lave & Wenger 1991:40). One of the case studies they used in their monograph was based on the research undertaken by Brigitte Jordan on Yucatec Mayan midwives in Mexico; from this research, they identified that the community of practice of midwifery involves much more than the technical, knowledgeable skill involved in delivering babies.

> A community of practice is a set of relations among persons, activity, and world, over time and in relation with other tangential and overlapping communities of practice. A community of practice is an intrinsic condition for the existence of knowledge, not least because it provides the interpretive support necessary for making sense of its heritage. Thus, participation in the cultural practice in which any

knowledge exists is an epistemological principle of learning. The social structure of this practice, its power relations, and its conditions for legitimacy define possibilities for learning.

<div align="right">Lave & Wenger 1991:98</div>

They explain that this participation starts as peripheral, increasing gradually in engagement and complexity to full participation in the sociocultural practices of the community. With the example of the Yucatec Mayan midwives, the apprentice is part of the family in which the experienced midwife works, often a daughter. The apprentice is not taught in any formal sense; she is not even likely to be identified as an apprentice but becomes involved in midwifery work by helping her mother from an early age. By the time she decides to become a midwife herself, she would already have substantial knowledge and skill from this life experience. At that point, she will start to pay more attention but will still ask few questions, taking on more and more of a workload as time goes on (Lave & Wenger 1991). She will have moved from peripheral to increased and then full engagement in the sociocultural practices of midwifery in their society. This is reflective of the historical approaches to learning the practice of midwifery discussed in chapter two, before the nineteenth century. Women became midwives through an apprenticeship without formalised teaching, gaining knowledge and skills through repeated experience of supporting labouring women.

In this perspective of learning, the role of the teacher is considerably less central than in other theories of learning. "Legitimate peripheral practitioners need broad access to arenas of mature practice and they need fewer demands on their time, effort and responsibility for work than full participants" (Tennant 1997). This suggests that there is little need for formal teaching, rather the context in which the learning takes place needs adjustment to give the learner the capacity to engage mutually with those experienced members and learn the norms of practice within the community. Wenger (1998) considers 'education' in the communities of practice and suggests that teaching does not cause learning, as what ends up being learned may or may not be what is taught. Teachers and instructional materials become resources for learning; the critical requirement in educational design is the opportunity for engagement. Education "cannot be a closed system that shelters a well-engineered but self contained learning process. On the contrary, it must aim to offer dense connections to communities outside its setting" (Wenger 1998:275).

In a research project undertaken by Burkitt et al (2001), the concept of 'communities of practice' is used as a theoretical framework to interpret contemporary nurse education in England. Their analysis supports the concept, identifying that, despite nurse education having moved beyond the traditional apprenticeship model usually associated with communities of practice, students experience similarities in the significant proportion of the programme delivered in practice. The engaged and embodied means of learning, which takes place in the practice environment, resonates with Lave & Wenger's viewpoint on learning.

Similarly there are synergies with the concept of 'communities of practice' and 'situated learning' with contemporary midwifery education. Clearly midwifery programmes, like nursing ones, do not take place in closed systems, as fifty percent of the programmes take place within the university and fifty percent in the community of midwifery or nursing practice. However, significant learning and socialisation into the occupation takes place in the community of practice (to be further discussed later in this chapter) and this is largely outwith the control of the educational institution. There is some interaction between the university staff and that of the community of practice, through the linking system described earlier, but the programme is not a self contained learning process in either sphere and the regular opportunities for engagement in practice are planned into the curriculum. This is necessary for the reproduction of the nursing or midwifery community; as Lave & Wenger (1991) identify, reproduction takes place over time by the gradual induction of new participants, or learners, into the ways, knowledge, skills and values of that community. Students of both midwifery and nursing require the opportunity for engagement offered through their experience in practice to actually become midwives or nurses rather than just students of midwifery or nursing.

Burkitt et al (2001) claim that student nurses, in reality, experience two communities of practice: one in the school of nursing and another in practice. The potential in this scenario, if the values of and in the two communities are not the same, is for dissonance or a gap between the theory expounded about and the reality of the profession. This is a common experience in student midwives; Billie Hunter (2002) found in her thesis on the 'emotion work' of midwifery, that students experience

profound and uncomfortable dissonance between the two spheres. Similarly, in an evaluative study of a new curriculum in midwifery, colleagues and I found a similar situation to exist in our own programme of education (McCourt & Thomas 2001). This 'theory/ practice gap' (for example Cooke 1991, McCaugherty 1991) has been well described in the nursing literature and focuses on the differences between the ideal and the real. The ideals of midwifery practice (for example, those presented in the literature review of current concepts in chapter three) may not be the reality which students experience in the community of practice.

Indeed, Wenger, McDermott & Snyder (2002) identify some important elements in communities of practice that may not be the norm experienced by current students of midwifery when in the practice environment. They discuss the energy in the community, the need for passion in the core members in order for the community to be attractive and stimulating to new members, making them want to be part of it. The current culture of the maternity services, discussed in chapter two, is described by Stapleton & Kirkham (2000) as one of powerlessness, with a resignation by midwives to their lot, a low sense of self worth and an overwhelming sense of helplessness and of low expectations. This is not likely to be the ideal of midwifery which students are exposed to in the classroom setting and may contribute to the potential for dissonance. With these as the cultural norms in the midwifery community of practice, it seems possible that students may not want to become part of that community. If they choose to remain, they may learn a pattern of behaviour which will perpetuate that disempowered norm, having had their learning situated in a less-than-ideal community. The ideal of an energy-filled and passionate community, which is exciting to new members, does not appear to fit the real situation in the current British maternity services.

Situated learning, as a learning approach, appears to have synergy with midwifery and nursing education. Despite the move from a traditional apprentice style of learning, the community of practice continues to have a significant impact on learning. This is complicated by the current delivery of midwifery education in two parts, in the communities of both the higher education institution and that of the maternity service. Students can be caught between these two communities (Burkitt et al 2001); they need

to survive both in the university and the practice environments. However, Burkitt et al (2001:32) claim that the

> tension between the imagined community and the actual communities of practice is a necessary, if uncomfortable one. Without the imagined community and its ideals, nurses would have no reference point for a critique of the current health care system and the restraints it places on the delivery of nursing care, nor would they have a vision of what nursing care should be like.

The fairness of using students as agents of change must be considered in this context. Although it may seem admirable that they are able to challenge the status quo, I know of colleagues who consider students as troublesome or annoying if they are too questioning. This may lead to tension between the student and her / his mentor in practice which is not productive. The challenge would appear to be in managing the dissonance so that the discomfort does not prevent effective learning. This will need to be set alongside maintaining sufficient ideals to ensure women receive the support and care they deserve.

Social Constructivism

This third, and final theory for discussion in this chapter, relates to both of the previous ones. Social constructivism is a philosophy of education which claims that all learning is socially constructed, that is, based on the values and beliefs of the social environment (or community of practice). It suggests that prior experience is an important part of that social construction and adults bring significant experience to any learning opportunity.

Renshaw (1995) suggests that this model of learning is based on the following assumptions about teaching and learning:
* learning is a social activity
* teaching is a joint activity with students
* learning is interactive and co-constructive
* teaching is guided conversation
* learning is self-regulated group membership
* teaching is assisting joint constructions
* learning is evaluating shared ideas and values
* teaching is enacting and role modelling community values

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Similarly to the principles of adult education, social constructivism emphasises what is happening to the learner rather than the teacher and focuses on interaction with the environment as a key to learning. Constructivism is based on the belief that there are many ways to structure the world (reality) and there are many potential meanings and interpretations of an event or concept. Previous learning and experience on the part of an individual will influence the way new events and experiences have meaning to each individual. Learning is more than receiving, storing and retrieving information; it is an internal process of constructing personal meaning in the mind and this takes place by fitting new information together with what is already known and understood.

For the midwife, practice is a key place where expertise is developed and skilled practitioners assist the learner to construct meaning through midwifery experiences. As highlighted above, teaching includes enacting and role modelling values; the teacher takes the role of one who creates and provides learning experiences and opportunities that facilitate the natural development of learner's decision-making abilities through various paths of discovery. Rather than the more passive approach highlighted in situated learning theory, social constructivism incorporates an active teaching role (although this does not necessarily conform to the traditional model of teaching). The teacher facilitates the learning by creating structured group discovery activities and by enabling students to construct their personal meaning from the situation.

Enquiry / Problem Based Learning

One learning and teaching method, which has social constructivism as its philosophical underpinning and which is becoming increasingly prevalent in midwifery, nursing and other health professional education is enquiry based learning. Enquiry based learning is an umbrella term for any teaching and learning method which uses the asking of questions and active seeking of answers as its basis. Problem based learning (PBL) is a specific method of enquiry based learning which has been considered as particularly helpful in learning professional knowledge and skills. The aims of problem based learning include the promotion of learning which is relevant to real life experience and which can be used and retained well by the student (McCourt & Thomas 2001). It sits in apposition to subject based learning in the sense that students are introduced to real life (or quasi real life) situations or scenarios and are facilitated to explore the learning

required to make sense of it. They learn about traditional academic subjects (e.g. physiology, sociology, psychology, pharmacology, ethics) in the context of a real situation rather than as a somewhat theoretical exercise, as may be in the case of subject based lectures. This approach is said to lead to 'deep learning' (Entwistle & Ramsden 1983) or learning which the student is actively engaged in and remembers as a result of this engagement, to be used in other, similar situations in future.

The evidence in favour of using a problem based approach in health professional education is impressive. It is not within the possibility of this chapter to provide an exhaustive literature search although three meta analyses review the strengths and weaknesses in depth (Albanese & Mitchell 1993, Berkson 1993, Vernon & Blake 1993). However, it is worth identifying some of the key points raised in the literature.

Sadlo et al (1994) review the positive outcomes of PBL which have been identified in the literature and include:
   * students find PBL courses interesting and relevant leading to high morale, enthusiasm and motivation
   * PBL promotes deep-learning approaches with improved command of subjects as courses progress and retention once the course is complete
   * critical reasoning is developed more quickly during work with problems and students are more intellectually active during PBL sessions than many traditional ones
   * clinical supervisors tend to rate PBL graduates higher than other students
   * PBL appears to produce superior outcomes in the areas of autonomy, interpersonal skills, satisfaction and fieldwork skills
   * tutors generally become excited and highly motivated using a PBL approach

These issues are corroborated in a number of other sources (Sadlo 1997, Murrell 1996, Creedy et al 1992, Boud & Feletti 1991, Mitchell 1988).

Problem based learning was first described in midwifery education in Britain by both Pansini- Murrell (1996) and Wise (1996), who piloted its use in specific modules. I was involved in introducing a whole midwifery curriculum using PBL (Thomas et al 1998) and with an evaluation of the programme (McCourt & Thomas 2001). The evaluation

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highlighted the challenges involved in moving both students and lecturers to a fundamentally different way of learning, but suggested that outcomes from the new programme were at least as good as the previous one and recognised that this could be seen as positive at a very early stage of implementation.

Although there remains a need for long term evaluation of PBL in terms of its effect on midwifery practice, there appears to be evidence that it is at least as good as traditional approaches to learning and teaching in the shorter term. Critics of the approach raise some areas of concern; medical students have been found to score lower on traditional basic science examinations and they perceive themselves to be less well prepared in basic sciences than their counterparts on conventional programmes (Albanese & Mitchell 1993). This may reflect the prevailing priority in medicine given to the knowledge of science rather than actually having a negative impact on the ability to use knowledge in practice. In our study (McCourt & Thomas 2001), some students became frustrated from having to rely on their peers in the acquisition of knowledge; they felt there were gaps in their knowledge if their colleagues did not pull their weight in researching topics. This can be a valuable learning experience in itself, as working as part of a team is critical in current midwifery practice, but it may feel negative to some students and interfere with their learning. In addition, the students' learning styles may or may not be congruent with this active approach as some learners prefer a more traditional passive form of education.

Further research is required to determine whether PBL has the potential for far greater benefits to practice in the longer term, when facilitated effectively, due to its synergy with woman-centred values.

Summary of Educational Theories

These three theoretical approaches to learning and teaching - adult learning, situated learning and social constructivism - all present relevant considerations for the development of an educational strategy for learning to be a midwife. There is some overlap in relation to the underpinning concepts; active engagement in learning, using previous experience, engaging with the community of practice and learning from real life scenarios. One significant challenge is that of dissonance experienced by students between the ideal and the reality of practice. Despite this dissonance being a potential

means to ultimately improving practice, the question of the fairness of using students as change agents does arise. The rest of this chapter presents a review of the research evidence in relation to midwifery education. This will identify whether the experience of students on current programmes of education is satisfying, whether these programmes are based on the theories described and which approaches are the most successful in helping students to become midwives.

Section Two - Learning the Trade

The following two sections present research findings from a number of studies undertaken, primarily in midwifery education but also from nursing, where particularly relevant. The research studies which are discussed in this first section relate to the learning which takes place in the practice environment (learning the trade). I have grouped them into three categories; role models, apprenticeship and learning by osmosis. These studies all consider the effectiveness of the learning which students undergo while they are situated in their community of practice.

Role Models

Several researchers have focussed on the significant impact which the midwife with whom the student works, her / his mentor, has in shaping the student. Both the specific mentor and the other midwives practising in the environment provide role models of both good and bad practice, from which the student learns.

Hindley (2000) identified a core theme in her study of clinical competence on an undergraduate midwifery programme relating to role modelling. Following interviews with eight midwives and eight students, she concluded that students absorb the values and beliefs about efficiency, organisational skills and practical ability from their role models in practice. This is seen as especially important in terms of passing the practice assessments; students subsume their own ideals and aspirations when being assessed by a midwife whose value system is not congruent with their own. On that basis, it would seem that students can learn from either following the good example of their mentor or by rejecting it if it does not fit with their personal world views. Once successfully through the practice assessment, an assertive and confident student may be able to avoid the mentor's approaches and develop her / his own style.

Specific traits in midwives were found to be particularly influential in Currie's grounded theory study of the preparation of student midwives for autonomous practice (1999). Currie identified that the intention of the supervising midwives would be to act as role models for students; students identified both positive and negative qualities which made an impact on them. The qualities which were admired most included honesty, empathy, good communication skills and the ability to avoid panicking in crisis situations. However when students witnessed a misuse of power, lack of assertiveness or conflicting advice for both women and the students themselves, they perceived these as negative qualities not to be emulated. Despite this rejection of the behaviours displayed, this negative reinforcement may have an unconscious effect on students. The development of behaviour patterns which are consciously recognised by the individual as negative (for example, a child who was abused is more likely to become an abuser as an adult) (Violence Against Children Study Group 1990) makes these 'bad' examples of concern to the educator. There is a need for longitudinal studies to determine whether those behaviour patterns witnessed as a student become part of the approach once qualified. It must also be recognised that the mentor is likely to have developed behaviours which are acceptable within the practice environment. The students will also be subject to the same cultural pressures, as described in chapters two and three; skills for coping with this potential stress will be an important part of preparing students for practice.

One of the main factors which influenced students' experience of learning in practice, in a study by McCrea et al (1994) of forty two midwifery students in Ireland, was the way trained staff practice. However, the students in this study did not just rely on qualified midwives as role models; due to shortage of staff, much learning was supported by more senior students. Role models could be anyone with more experience. The researchers in this study concluded that, if students observe their role models participating in activities which did not specifically relate to midwifery tasks (for example, administrative duties), this could impact on the likelihood of those students choosing to remain in midwifery at the completion of their educational programme. This would confirm the value of having positive role models as part of the practice experience for student midwives in preparation for undertaking the role once qualified and the negative effect of witnessing non-midwifery duties as a significant part of the role.

Fraser (2000) identified two key aspects of the midwifery course which were most instrumental in preparing students for their first jobs after qualification - the student's own personality and the practice-based assessors. The assessors who provided students with opportunities to take responsibility for providing care without continuous direct supervision towards the end of the course contributed to an increased confidence in the students in this study. These role models were exhibiting a sense of trust in the students which had a positive impact on the student's self-perception. This is further confirmation of the effect of role models' behaviour on student experience.

Cavanagh & Snape (1997) examined the causes of self-perceived stress in 199 student midwives by asking them to record incidents in their programme which contributed to 'a little', 'much' or 'very much' stress. In the 'much' and 'very much' categories, the behaviour of staff in practice was a significant factor. Uninterested and unfriendly staff (including midwives and doctors) who treated women insensitively caused many of the students to become stressed. This study clearly shows that negative exposure to role models impacts on how students feel about midwifery and this is likely to impact on the quality of the learning experience. It will also contribute to the behaviour of students as they take increasing responsibility in their own practices; students may be likely to try to avoid those behaviours which caused them to be stressed in order to be more supportive to women. However, in an environment where this behaviour may not be the norm, students and newly qualified midwives may find it a challenge to keep true to their values.

In addition to the midwifery research, there are a number of nursing studies which have looked at the issue of role modelling. Kosowski (1995) found in her study on the learning of caring skills that role modelling was the most significant factor. Both education and practice staff who demonstrated genuine warmth and respect, with caring behaviours and mannerisms, were observed and imitated by the students as a means to developing similar approaches in practice. Campbell et al (1994) also found role modelling to be one of the most important influences on student nurse learning in practice. 'Good' role models were those who were organised, encouraging, outgoing and who had good relationships with students, patients and other staff. These instructors were identified as crucial in shaping students' attitudes to nursing. Davies'

(1993) study confirms the impact of the way in which role models behave on the development of student nurses. The characteristics of clinicians, which were perceived as both positive and negative, were reported as having significant impact on care provision and nurse / client interaction by students in interviews following initial and subsequent practice experience. "The role models were seen to facilitate student learning by virtue of the characteristics they displayed and things that they actually did" (Davies 1993:634). Baillie (1993) also found that Project 2000 nursing students on community placement identified the mentor as crucial to their learning. Students described situations where they had been impressed by the mentor's expertise and attitude, seeing them as role models of good practice.

These studies confirm that the observation of, and working with, midwives or nurses in practice makes a significant contribution to learning. Students learn by positive reinforcement of 'good' practice and negative reinforcement of that which they perceive as 'bad'. This evidence highlights the importance of students being exposed to positive role models during their educational programme to help them shape their ideals and expectations. This corroborates the position in relation to situated learning described earlier by Wenger, McDermott & Snyder (2002) which suggests that energy, passion and a positive environment will help to develop practitioners who are committed to practice and who want to remain a part of the community.

Apprenticeship

Reid (1986) explored the training of American lay midwives using an apprenticeship model at a time when both lay midwives and nurse-midwives were relatively uncommon in the U.S. (see chapter two). She collected data by participant observation with 49 lay midwives across a number of States and in a variety of settings. The study showed that this approach extends the function of the role model considerably with a long term, intense relationship between apprentice and teacher creating a personal education in the skills and 'art' of the occupation. In addition to technical and interpersonal skills, the teacher is expected to be a role model for the way a midwife contributes to the building and maintenance of confidence in women.

It is recognised that there are limitations to this approach to learning in the sense that students do not benefit from a breadth of exposure to ways of practice nor is there a

consistent standard which can be assured due to the individual nature of each midwife's caseload. The student lacks the opportunity to witness a variety of ways of dealing with situations which may help in her / his personal construct of midwifery practice. However the closeness of the apprentice / teacher relationship over a long period of time offers other strengths which may be worth considering in programmes of preparation. It also bears resemblance to the Yucatec Mayan midwives described earlier where the apprentice moves from peripheral to full engagement with practice over the period of apprenticeship. This approach to learning is quite different from the norm in the U.K. but is likely to have strengths in engaging the student in the community of practice.

Learning by Osmosis

Although students are normally assigned to a mentor or assessor in practice during midwifery training, there are a number of examples in the literature of times when these individuals do not effectively teach students. The learning is left to be by 'osmosis'; students are expected to watch and listen and learn from situations rather than having them explained and theory linked to practice explicitly. This appears to similar to 'situated learning' where the learner is exposed to practice without formal teaching. Despite Lave and Wenger's (1991) recognition that this can be an effective mechanism for learning the trade, the evidence from these studies suggest that this is an unpopular way of learning for some students.

Chamberlain (1997) undertook an ethnographic study to identify how student midwives actually learn in a clinical setting. Twenty five students were observed and interviewed over an 18 month period; managers, teachers and midwives were also interviewed. There were some examples of effective teaching in practice by well experienced midwives with good communication skills. However, as this was not the most common scenario, three strategies for learning were employed frequently as a result of inadequate explanation and facilitation of learning. Firstly, observation was a major learning tool; students were expected to watch a procedure and then understand and be able to practice it. Sometimes there was explanation but this was often just once and too brief to be useful, especially in the case of experience in hospital (the community midwives used the drive between clients as an opportunity for feedback). Secondly, indirect learning took place when students listened to midwives' interactions

with clients, doctors and each other. The prime objective of these conversations was not to teach the student but the information provided did help students to understand and learn. Thirdly, trial and error was the main method of learning in the absence of structured teaching in practice. Students were told to perform a task and to call if they needed help; if they did seek help, the midwife commonly took over the situation and sent the student to perform other tasks rather than using the opportunity to include the student in the decision-making in the original scenario. The researcher concluded that these methods of learning, with little direct explanation, teaching or supervised engagement, created anxiety in students and this anxiety could interfere with learning. An outcome of these approaches could also be misunderstanding; in the absence of the mentor checking out the student's understanding, habits in practice could be formed without an appropriate evidence base. However, if the concept of situated learning is accepted as a valid mechanism for learning, the issue may be more one of expectation. Students clearly expected to be taught when in practice; the fact that they received very little direct instruction did not meet their expectations and created anxiety. However, it is also very likely that this would not meet the expectations of the curriculum designers of that programme either, as we are culturally used to active teaching as part of learning in Britain, despite newer methods increasingly expecting students to be more active than teachers (see enquiry based learning page 102). There seems to be a mismatch between what the student actually experiences during their practice placement and what is both expected of and designed into the programme. It seems likely that valuable learning did take place but that there was frustration on the part of the students, as it was a passive and not active process.

Begley (1999a, 2001a, 2001b) studied 125 student midwives in Ireland to explore their opinions, feelings and views as they progressed through their pre-registration programme. Similarly to Chamberlain, she found that students were given little clinical teaching and guidance and were not actively helped to develop the skills of decision making and judgement. Much of their learning took place by trial and error; they felt 'thrown in at the deep end' and lacked much support or guidance from qualified staff. The status of students as employees and a major part of the work force in Ireland clearly left little time for these students to be taught while in practice. Their learning was left to them to acquire alongside providing direct care in environments which were often very busy and under staffed. Although the status of student midwives as learners

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in Britain is somewhat more protected, the expectation that they will learn from being there rather than from direct teaching remains similar. The issue of expectation arises from this study as well, as these students were left feeling frustrated by the lack of direct, active teaching.

Currie (1999), in a study described earlier, found evidence that the various experiences which students encountered were rarely discussed as a way of enhancing learning. Despite the acceptance by the midwives supporting the students that reflection is an important tool for learning, it was rarely used. Two factors were considered to influence this, the lack of time and lack of awareness by mentoring midwives about the need for 'powerful dialogue'. The students in this study also seemed to be left to put the pieces of practice puzzle together themselves without active teaching and explanation.

Once again, the nursing literature provides some evidence that similar issues arise in the student nurse experience. In a longitudinal study of eight degree students in Oxford, Spouse (1996) found that students had relatively little 'coaching' (or clinical teaching) in their training, being left to work alone or with little apparent supervision. These students found it very helpful when they did have active teaching but it was not a common experience. Eighty one students in a study in Ireland by Condell et al (2001) reported that 'observing and practising' were the best method of learning. Staff nurses were considered the best people to learn from but, once again, they reported that some staff nurses were 'not interested or prepared to teach'. These two studies provide some confirmation that active teaching could also be improved in the clinical experience of student nurses.

Summary of Learning the Trade

This section of the chapter has explored some research evidence relating to the effectiveness of learning in practice. 'Learning the trade' of midwifery clearly happens substantially through practice experience, working with midwives in the support of women having babies. The review of this evidence, however, identifies significant limitations in the process. Role models can provide good examples which students want to emulate but students also witness behaviours which they feel are unhelpful and undesirable. Current mentors of students may be repeating their own experience

of learning; they may have had little formal teaching in practice and so repeat the experience for their students by not prioritising the teaching component of their role. Effectively this may be another example of role modelling with the midwife as teacher rather than as practitioner. Students may learn less-than-ideal teaching practice as well as clinical practice through their mentors.

Long term relationships in the apprenticeship model can provide positive experiences for students but they may lack exposure to a breadth of practice which could contribute to their repertoire of skills and abilities. Explicit and effective teaching in practice seems to be limited for many students who are left to learn how to practice by 'osmosis'. The question remains as to how effective this 'situated learning' is, as there is clearly an expectation on the part of students of midwifery and nursing in these studies that they should have active teaching not just passive learning in practice.

Section Three - Learning to Behave

Students learn more than the 'art' of practice while in clinical environments; they learn the accepted norms and behaviour patterns of midwives as part of that community of practice. This section will focus on the research relating to the socialisation of midwifery and nursing students, identifying how they learn to become part of the culture and cope through that sometimes painful process (learning to behave). Although the literature search revealed a number of sources pertinent to the socialisation of nurses, very little research is evident in midwifery. Therefore this discussion will draw on studies from both groups.

Socialisation

Professional socialisation has been defined as the process by which the individual learns the culture of a profession; in so doing, students acquire the values, attitudes and practices that make a profession distinct (White & Ewan 1991). They effectively 'learn to behave' in a way which is in keeping with the norms of the occupational group. Those who are uncomfortable with those norms appear to have two choices - make the transition or leave the profession. Studies have explored a variety of ways in which this transition takes place and its implications for education.

Rosemary Mander (1989) undertook a large study in Scotland; the prime purpose was to explore the experience of students on both the 12 and 18 month post-nursing midwifery programmes at the time when educational preparation for registration was changing. This change provided an ideal time to examine whether students felt better prepared by a longer programme (and therefore more likely to stay in midwifery); it also provided an opportunity to try to determine whether a longer course gave more time for socialisation. One item included in Mander's questionnaire aimed to assess the degree of occupational socialisation by ascertaining the extent of identification with the occupational group, midwives. The respondents were asked to range nine characteristics applied to midwives. The results showed, in the group who completed questionnaires both at the start and completion of the programme, that the favourable or positive descriptors (e.g. cheerful, sincere) increased as responses more during the longer course with a similar decrease in negative, authoritarian characteristics (e.g. determined, intolerant). Although these changes were not statistically significant, Mander concluded that there is a possible suggestion that those taking the 18 month programme become more favourably disposed to midwives, and therefore midwifery, than those on the 12 month course.

From this study, it is suggested that time may have a role to play in the transition process. However, although this is a small part of the research undertaken with a limited attempt to interpret the significance of these particular findings, other questions arise from the change in values which these students described. It is not clear whether the change, especially in the case of the negative descriptors which decreased with a longer socialisation period, was due to their increased understanding of the role (i.e. some of these behaviours are necessary for some reason) or to a 'desensitisation' process. Should the latter be the case, this is somewhat worrying for the women being cared for by these midwives. Students may learn to be less critical of unpleasant behaviours in their colleagues, adopting these themselves to fit the group norms.

Woodward (2000) found, in her ethnographic study of caring in maternity and palliative care settings, that midwifery activity often appeared task-orientated and, at times, unresponsive to the needs of women. There were missed cues of pain, undetected fear and lack of attention demonstrated by the midwives in this study. If this behaviour was frequently displayed in a setting in which students are learning, the learners may

not be exposed to sensitive awareness and fail to develop the skills of effective support for women. They may become desensitised during their training period through persistent reinforcement of priorities which do not relate to seeing and meeting women's emotional as well as physical needs. The priorities of completing tasks rather than being 'with woman' could easily influence the behaviour of students who, by far and large, want to learn to fit in (see discussion to follow). This being the case, the changing values which the students' in Mander's study (1989) showed could indicate that they perceived intolerance and determination as less problematic characteristics for midwives because they themselves were moving in that direction.

The task-orientated approach to midwifery practice is defined as 'getting through the work' in Hunt and Symond's (1995) ethnography of work in the labour ward. In that study, midwives were observed handling intrusive and invasive procedures in mechanical and routine ways (i.e. the woman's individual situation and feelings were largely ignored, each case being handled with a set pattern of behaviour). As was the case in Woodward's study, there were cases where the woman's pain, anxiety and distress were not really considered, with the main priority for the midwife being to get the work done. This raises the question as to what the real work of midwives is; from Hunt & Symond's experience, it related to admitting women to the labour ward only when they were very likely to progress quickly, getting the baby delivered and then transferring the woman to the postnatal ward all as quickly as possible. There was little emphasis laid on helping the woman through the experience; it was a race to get the whole process over so that a bed on the labour ward could be made free for the next labouring woman coming in.

Although this research did not focus on the experience of student midwives, there were some issues discussed which related to students. The ritualistic approach to handing over the care of a woman to the oncoming shift of midwives is a particular example. The need to learn how to give a hand over in order to be part of the 'in crowd' (p118), accepted by the midwifery community in that unit, was an important step in increasing the comfort of students. This example highlights the desire students may have to fit in with the culture and practice which surrounds them; the possibility that learning behaviour which is common-place but not woman-sensitive, in order to be accepted, cannot be ignored. The midwives in this study would have been demonstrating

priorities of work which may not have been in keeping with the needs of the women as much as the needs for the smooth running of the organisation. They were also likely to be demonstrating coping strategies to deal with the emotional effort involved in supporting women through very demanding situations. This routine practice would be much less demanding in terms of the personal energy required to deal with labouring women day in, day out. It sets up the question as to the effectiveness of a maternity service which places this level of demand on the midwife. Although the service may run smoothly with a consistent group of midwives working on the delivery suite who know the ropes and are confident in emergency as well as normal situations, women may be likely to receive less personal and supportive care. The midwives will be meeting women continually with whom they have no prior relationship, having to get to know them quickly in order to be able to determine their preferences and needs.

The desensitisation of practitioners to the needs of their client group is explored in a literature review / discussion paper by Greenwood (1993). She recognises that one of the motivators for the change in nurse education, from the traditional hospital based courses to diploma level ones in higher education, was to decrease the element of professional socialisation in nursing which had led to a relative desensitisation of some student nurses to human need. This is supported by Menzies' work (1970) where nursing was studied in a traditional teaching hospital before the move to higher education. She found that one of the strategies for coping with the stress of nursing was to deny the significance of the individual. This emotional distancing between nurse and patient was used to protect the nurse from the added stress involved in intimate care situations by considering the patient as a case rather than as a person. Similarly, Greenwood (1993) claims that the repeated exposure to less-than-caring nursing practice and the 'compartmentalisation' of concepts of theory and practice in traditional courses had resulted in some less-than-caring students. Her discussion highlights that the change to programmes in higher education institutions has not been as successful as intended, identifying that there is a continued need for students to be exposed to caring role models. Greenwood's proposal is that nurse teachers should be actively involved in clinical learning environments to support both students and hard-pressed clinical nurse colleagues.

Although, on the face of it, the involvement of teachers in the practice experience of students may seem a reasonable way forward to ensure that students are socialised by role models with appropriate values (and probably significantly less pressure on them), there may be challenges associated with this. Not surprisingly, Wilson & Startup (1991) point out that it is doubtful that students, teaching staff and ward staff all employ a single concept of the 'good nurse'. In their study of Project 2000 students in South Wales, students perceived from very early in their programme that teachers would expect a different performance than sisters or charge nurses. They learned to do things the 'school way' if there was a teacher present and they tended to consider this as the 'right' way. The conclusion from their research was that there needed to be more integration in the programme with teachers acting as practitioners and practice staff involved in the theoretical component of the course. A unified approach was proposed which would reduce the conflicts which learners experience.

Reutter et al (1997) also recognise that students internalise values from both the university and clinical practice worlds. A longitudinal study of student nurses on a four year degree programme in Canada was undertaken to monitor the steps of professional socialisation. They found that as students progressed through the programme, they did not accept uncritically the values of the professional school but examined and reflected on these to derive for themselves a 'bedside model of reality'. These researchers suggest there may be a positive element for students being required to adjust to differing situations throughout their studies as this may prepare them to cope with uncertainty and structural change inevitable in the world of health care practice.

Fitzpatrick et al (1996) explored the key influences on the professional socialisation of students on three different pre-registration nursing programmes in the U.K. (certificate, diploma and degree level courses). Similarly, they found that high quality role models from both education and practice were considered as crucial to socialisation by students in all three groups.

In several other papers, other important issues in socialisation are raised. The learning to conform (as discussed in relation to Hunt & Symond's work above), which takes place primarily in the clinical environment, was found as a significant element in

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socialisation of nursing students by Gray & Smith (1999), Andersson (1995) and Bradby (1990). It was recognised that the process of socialisation is not homogeneous by Wilson & Startup (1991); students are often presented with conflicting and divergent values which are supposed to be integrated in order to become a 'good' nurse. Howkins & Ewens (1999) found students to be active in their own socialisation, bringing a personal construct of the practitioner with them to the programme which only changes for some students; others appear to make little change. With the pressures to conform which surround students while in practice, it is interesting to note that some have the strength to resist changing their approaches. This does raise the question as to whether the students who did not appear to have changed in Howkins & Ewens' work already had similar outlooks to the cultural norm of practice before beginning the programme of education. As their study took place with students on post qualifying programmes for community nurse practitioners, this may well have been the case as initial socialisation into nursing would have already taken place.

These studies accept and reinforce that the socialisation process is a fundamental way in which students of midwifery and nursing learn to behave. They learn the norms by watching and listening to their role models; some of what they learn will be of positive benefit to the women / clients. However they may also learn to be less sensitive to human need by following the behaviour of practitioners who place values more on the tasks to be done than on the needs of clients. Learning to conform seems an important part of socialisation for most students to increase their acceptance by clinical colleagues and therefore to increase their sense of comfort and belonging.

Coping Strategies

> I did offer to make the tea (for the midwives) and that seemed to help things along. It was almost like a hierarchical thing. It paved the way to being accepted.

This remark from a student midwife in Yearley's study (1999) demonstrates an approach adopted by a student midwife to help her cope and be accepted by the midwives. One of the themes in this research was 'learning to fit in', a part of the learning which took a great deal of personal energy for this group of students on the long pre-registration programme for non-nurses. They used other strategies to help the acceptance process, in addition to making the tea, including 'looking busy'. These

mechanisms were used to help cope in an unfamiliar environment where the student felt little social status despite often being a mature individual with life experience.

The easy option for students in Currie's study (1999) to assist in this acceptance was to 'do as you're told'. Students felt unable to challenge in a hierarchical system and found compliance more comfortable than questioning any orders. This is another coping strategy used to achieve harmony and make students feel comfortable in a new setting.

Davies & Atkinson (1991) describe strategies which students on the post-nursing shortened midwifery programme used to help in their adaptation to midwifery practice. Several students in their study took comfort from both understanding the term and being skilled enough to 'do the obs' (or check the vital signs of women) on the antenatal or postnatal ward. Familiarity with this aspect of care helped them to feel that they were making a contribution and boosted some confidence in the 'strange and threatening midwifery environment'.

This coping strategy is similar to those described by Melia in her seminal study of socialisation in student nurses (Melia 1987). The 'unwritten rules', which students learned to obey, determined behaviour patterns in practice and included 'looking busy', 'pulling their weight' and avoiding too much conversation with patients as 'talking isn't working'. The importance of learning how to gain membership into the occupation (how to behave) often took precedence for students in this study over learning how to nurse. Gray & Smith (1999) also describe ways students learn to conform in nursing. 'Fitting in', 'mucking in' and 'learning the routine' were terms which these students used in identifying how they learned the rules of behaviour. Similarly students in Andersson's study (1995) describe the demands of the practical side of nurse training as 'having to fit in, make do and be useful'.

These studies in midwifery and nursing identify the stress which students experience in unfamiliar environments. Successful adaptation requires strategies to help cope with the discomfort experienced; students work hard to learn the rules of behaviour and fit into the mould as soon as possible to gain acceptance.

Workers not Learners

One particular feature of midwifery and nursing educational programmes, as a result of fifty percent of the learning taking place in practice, is the potential for conflict. This conflict comes from the role ambiguity of being a worker versus being a learner. One of the conditions for 'situated learning' to be effective, discussed earlier, relates to the need for the student to have fewer demands on time, effort and responsibility in order to be able to learn (Tennant 1997). Achieving a fair balance seems to be problematic for some learners.

In pre registration nursing programmes, students are now defined as supernumerary i.e. not part of the workforce. This came about with the move of programmes of education into universities and the new 'Project 2000' diploma level courses in the early 1990s. Although this has not completely resolved the issue in nursing, the main discussion in the literature about this situation is in relation to midwifery. Despite midwifery programmes also now being delivered in universities, the post nursing eighteen month midwifery students are employed by NHS Trusts and salaried throughout their courses. Therefore these students are considered as part of the workforce and the conflict which permeated both professional groups of students in the past rests mainly with those of midwifery at this point.

One of the themes in Begley's study of student midwives in Ireland (1999b) was 'we're workers, not learners'. These students, as part of the workforce with a very limited amount of time in the classroom setting (13 weeks out of a two year programme at the time of the study in 1995) felt that they were just a pair of hands in very busy wards areas. Their learning needs were largely ignored, care was delivered in a task orientated way and there was a hierarchy of activities in which the student could participate (for example, the second year students were able to do the 'important' work like abdominal palpation and fetal tocography while the first years were left to wash women and add up fluid balance charts). This approach to practice learning would have a profound influence on the way that students learned to behave; they would very quickly have to adapt to the work environment with the needs of the service taking priority over their needs as learners. Begley suggests that the needs of women are also considered as secondary to the smooth running of the service.

Other studies have also alluded to the challenge students experience in fulfilling two roles in practice, learners and workers (McCrea et al 1994, Chamberlain 1997). This duality may cause a crisis of identity for students with pressures being applied from two sources - the needs of the women and service versus the requirements of the university and programme of study. It may well have an important impact on the way which students learn to behave in practice as the former is likely to take priority over the latter in most cases.

Summary of Learning to Behave

This section of the chapter has focussed on the ways that students learn to behave in practice. The socialisation process has been explored by a number of researchers, primarily in nursing, who have identified that students learn to conform to the norms of behaviour from very early in their programmes. Two particular studies in midwifery have raised the question as to whether part of the socialisation process is in learning to be less sensitive to the needs of women, an issue which was one reason for the move of nursing education out of hospital settings. Desensitisation may be an important way of coping with stressful environments but it does not fit comfortably with the vision of a woman-centred maternity service. Students use a variety of coping mechanisms to help maintain personal equilibrium in new and sometimes threatening environments; all of these seem to aim for acceptance by the qualified staff. The additional challenge set for students in practice, where they have competing demands as both workers and learners, may increase the need for effective coping strategies.

Conclusion

This chapter has examined the evidence base regarding midwifery education, initially setting a descriptive context of the way midwifery education is currently organised and discussing some theoretical concepts relating to learning. It proceeded by drawing on relevant studies from both midwifery and nursing to identify key issues which will inform the development of an educational strategy. Within the two themes, 'learning the trade' and 'learning to behave', a number of repeating concepts have appeared.

The importance of the role model as a source of learning cannot be underestimated as many studies identify these individuals as key players in practice learning. The evidence suggests that the positive or negative reinforcement of behaviour towards

women or clients makes a significant impact on the way students develop an occupational identity. Despite the intention that student midwives and nurses should be supported in practice learning by a mentor, there is a lack of structured teaching in the experience of many students. They adopt ways of learning which do not rely on direct teaching by practitioners including observation, indirect teaching and learning by doing (in effect, learning by 'osmosis'). Although these approaches will provide a certain amount of success, misinterpretation and error are possibilities which cannot be ignored. The need to adopt these also reflects on the low level of importance attributed to learners in the practice environment. However, the concept of situated learning suggests that learning within a community of practice is normally passive and not actively facilitated. Students of nursing and midwifery at this point in the U.K. do not seem to find that a comfortable basis; there is frustration if active teaching does not occur as it is probably what most have grown to expect throughout their educational process despite being adult learners who possibly should have the ability to self direct effectively.

In addition, the climate in current maternity services tends to lack the positive culture which is the ideal for 'situated learning'. It seems likely that a different, more enthusiastic and passionate 'community of practice' could be more open to supporting students' questions and possibly lead to a different type of midwife on qualification.

A major part of the learning which takes place in practice is the 'learning how to behave' in the culture of the occupation, the socialisation process. The nursing literature provides abundant evidence about the significance of this process to pre-registration students. Less is evident in the midwifery research but one worrying concept has been identified in relation to this process. The potential for desensitisation, or becoming less responsive to human need, exists within the current approaches to learning in practice. Along with this desensitisation (which is probably a coping mechanism), students learn other strategies for dealing with the intensity of experience in practice. These include patterns of behaviour which will be considered as 'good' by qualified staff - 'looking busy', 'doing the obs', 'doing as you're told'. This behaviour helps them to 'fit in' and be accepted by members of the occupational group and makes the students transition less painful. There may be added tension in the practice

experience when students are employees as well as learners; the need to be a significant part of the workforce can take priority over their needs as learners.

This review has set a powerful scene for the development of an educational strategy. The evidence suggests that all is not well in the current patterns of practice learning for student midwives. Interestingly, there has been limited research published in respect of the more formal part of the curriculum, that which takes place in the classroom. This, in itself, may identify a priority within midwifery, suggesting that the learning which happens in practice is regarded as the most important and powerful part of the educational programme. The lack of research into the classroom experience of student midwives (Fraser et al's work discussed earlier was based primarily on curriculum documentation rather than the actual experience) means that we also have little evidence as to the variation of quality which may exist from programme to programme across Britain.

Recognising the ideals described in the previous chapter which relate to priorities in midwifery practice, set against the disempowered position of midwives in the current maternity services, it may not be surprising that students are low in the 'pecking order' of priorities. Midwives are working to meet many demands - medically dictated, evidence-based, contemporary practice (with risk both managed and minimised in a litigious society) versus the social caring relationships in which individual women's needs are met through effective communication and continuity of contact. Students seem to be frequently left to their own devices in terms of learning the balance of these priorities, having to learn 'the trade' and 'how to behave' by observation and osmosis from role models of variable quality.

Having identified some significant elements in respect of learning and teaching ('how' students learn) to complement the key concepts in contemporary midwifery writing presented in previous chapters ('what' students need to learn), the challenge was set to consider what additional theory would enhance the current learning experiences of student midwives. The next chapter explores the place of theory and sets out the research approach used for the empirical study in this project.

Chapter Five
Research Methodology

Introduction

The first aim of this chapter is to reflect on the purpose and importance of theory, which was discussed in chapter three, as a starting point for deciding on the relevant research approach for this project. This leads to the second aim, providing a rationale for the choice of research methodology in this project, that of grounded theory. Grounded theory is based on a 'model of theory generation, where theory is discovered from, and therefore grounded within, data' (Glaser & Strauss 1967:1). I will explore this approach to research, identifying its strengths and potential in this particular study.

Although the project started with the grounded theory approach in a conventional sense with common data collection methods (interviews in phases one and two), as I discussed in the introduction, my data collection method diverted somewhat in the third (personality tests) phase. This different type of data collection did not mean that I diverged from the principles of grounded theory but used more varied means to question my findings and look for explanations than are often used in grounded theory approaches. The specific discussion about the data collection methods will be provided in two ways; interviews (including issues relevant to interviewing women and focus group interviews) and narratives are discussed in this chapter, as the approaches are used in three of the four phases of the project. However personality testing, as a distinct approach, will be included in chapter eight to keep it in the context of that phase of the project.

In addition to an overview of grounded theory methodology, this chapter will also discuss the overarching issues of validity, ethical considerations, practitioner research and limitations which are pertinent to each phase of the project.

The Role of Theory

As identified in chapter three, theory is implicit in the practice of any occupation; in order to practice effectively, all practitioners must have some level of knowledge base

and be able to use it. Over the past three centuries, midwifery knowledge appears to have been increasingly subjugated, appearing inferior to the priority attributed to medical knowledge with its higher status and authority. In addition, theories from other professional groups and academic disciplines have traditionally been taught to student midwives with an attempt to 'apply' that knowledge base to the practice of midwifery, rather than attempting to uncover the unique knowledge and contribution of midwives. In the study discussed in chapter 4, Fraser et al (1997) identified that the method of teaching and learning used in some midwifery programmes also presents a subliminal theoretical stance to students. The 'technical rational' approach aligns with the scientific method where learning facts comes before trying to use knowledge in practice. In this approach, theory is not generated from practice but is seen as a distinct and removed concept.

The uncovering of implicit theoretical knowledge, often deeply embedded in the practitioner, is an important step to being able to articulate what is unique about midwifery. The purpose of this study was to clarify key theoretical concepts in midwifery which should underpin an educational strategy. I wanted to articulate some of this embedded knowledge in a way which would be useful in helping students to become woman-centred midwives.

Research Paradigm

At the beginning of the project, my belief was that current midwifery education programmes fail to help students learn explicitly the key theoretical concepts underpinning the role of the midwife. The focus on how to be a midwife, the activities and tasks required to be a safe practitioner (with some important discussion on relevant ethical and professional issues) are made explicit. However, the belief systems which will help students to become woman-centred appear to be left more to the mentorship model, where they learn by (good and bad) example from practising midwives. The literature review has highlighted many historical and contemporary important issues in midwifery but failed to conclude any specific, essential concepts which are derived empirically and can underpin programmes of education.

The process of learning has also been explored from the literature and indicates that student midwives may be constrained in learning by less-than-ideal examples in

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practice in many ways. The situated learning which takes place in the practice environment may lead to the perpetuation of the cultural norm and, if this norm is not directed at meeting women's needs consistently, students may learn an approach to care which fails to meet the ideals of being 'with woman'.

The decision about the appropriate research paradigm, suitable to explore fairly subtle nuances, began by both considering those open to me and by considering my personal epistemological stance.

Ideology

> One's concept of reality helps determine what questions one can ask, even what one can imagine. To a large extent, it defines one's 'truth'. To choose research methods well, one must examine deeper issues of meaning and how meaning is constructed.
>
> Cassidy 1994:6

The world can be viewed in many ways; there are two broad ideologies which influence research approaches, defining a spectrum of methodologies. On one end of the spectrum, there are those who see the world as based on universal laws with an insistence on objectivity and neutrality (Thompson 1995). For these individuals, the issues of prediction, explanation and control are important; they are positivists who see things as measurable and definite. At the other end of the spectrum, there are those who believe that knowledge is socially constructed with subjective and individual meanings being important. Multiple realities exist; truth is therefore an elusive concept to be interpreted in a context (Holloway & Wheeler 1996). The goal for these people is to try to understand, not explain; they consider things from a holistic point of view and do not try to reduce and measure things. The unpredictability of nature is accepted and even welcomed for its rich variation and individuality.

Guba & Lincoln (1994:105) point out that "the basic belief system or worldview that guides the investigator" is of prime importance in "ontologically and epistemologically fundamental ways"; the methods used for the research itself are of secondary importance. They highlight four main paradigms currently informing and guiding inquiry: positivism, postpositivism, critical theory and constructivism. In a comprehensive analysis of the distinctions between these four paradigms, their critique

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identifies the limitations of the "received view" of science (including both positivism and postpositivism) when investigating human behaviour and its meaning. They suggest that there are three fundamental questions which inquirers should engage with in order to determine their world view and therefore inquiry paradigm (Guba & Lincoln 1994:108).

1. The ontological question: What is the form and nature of reality and therefore, what is there that can known about it?
2. The epistemological question: What is the nature of the relationship between the knower and would-be knower and what can be known?
3. The methodological question: How can the inquirer (would-be knower) go about finding out whatever he or she believes can be known?

In the constructivist paradigm, the ontology (nature of being) is relativist; reality is local and specifically constructed rather than 'true' in any absolute sense. The epistemology (grounds of knowledge) is transactional and subjective; findings are created as investigation proceeds. The methodology (science of method) is hermeneutic and dialectic, or open to interpretation based on opinion, discussion and logical disputation. Interaction between and among the investigator and respondents is key. The constructivist paradigm would appear to be in keeping with my personal world view and with the desire to understand and reconstruct knowledge about the nature of midwifery. This underpinning paradigm would inform my choice of research method.

"Different research methods or designs are appropriate for answering different research questions" (Sandall et al 2000:158). The research continuum, with the two ends of the spectrum as described, offers a multitude of approaches which will provide differing types of evidence, based on the questions asked. Sandall et al (2000) suggest that these move from exploratory to descriptive on to correlational to quasi-experimental and then to experimental. From this spectrum, the most appropriate methodology to support my research 'question' appeared to be one which favoured the naturalist or holistic tradition. It aims to allow the researcher to enter the worlds of others in order to "render these worlds understandable from the standpoint of a theory that is grounded in the behaviours, languages, definitions, attitudes and feelings of those being studied" (Denzin 1971:166). An exploratory research approach would allow me to consider midwives' experiences with the aim of developing a theoretical base for an educational strategy.

Qualitative Research

Qualitative methods are primarily concerned with indepth study of human phenomena in order to understand their nature and the meanings they have for individuals involved; the intention is to develop theory inductively from the data rather than to test theory 'scientifically' (Hunt 1985:117). This approach favours respect for personal experience as a valuable source of insight into a group's reality. Strauss & Corbin (1990) refer to qualitative research as any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification. Kearney (2001) claims that the strength of qualitative research is that it produces knowledge in the inter- and intrapersonal realms. The lived experience of being a midwife, possibly something which is seldom expressed explicitly and which is fundamentally based on interpersonal relationships, appeared to me an issue which would be best pursued with a qualitative approach. Having decided to use a naturalistic approach to the research, I needed to ascertain which of the many qualitative methods were most suited to the investigation at hand.

Increasingly, qualitative research methods are being embraced by nurses and midwives, having had their roots in the social sciences (Streubert & Carpenter 1995). These approaches allow exploration of human experience and can make a significant contribution to practice. However, Baker et al (1992) suggest that there is often a 'slurring' of methods in nurse research; "failure to explicate qualitative methodologies is resulting in a body of nursing research that is either mislabelled or is classified broadly as qualitative and subject to charges that qualitative research lacks rigour" (p1355). This challenge suggests that a close investigation of the various methods is imperative to ensure an appropriate fit.

"It is the strength of the grounded theory approach, especially as it is informed by the interactionist philosophy, that conceptualisations are grounded in the empirical world" (Orona 1997:177). The roots of grounded theory are based in the sociological school of symbolic interactionism, which focuses on the meanings of events to people and the symbols they use to convey that meaning (Baker et al 1992). Symbolic interactionists tend not to believe that statistical data provide any great insight into human behaviour, rather researchers must attempt to grasp the actor's view of social reality by "feeling

one's way inside the experience of the actor" (Haralambos & Holborn 1991:709). The search for interactions and the meanings associated therein is underpinned by the constructivist paradigm of inquiry, discussed earlier.

The ontological and epistemological stances of both interactionism and constructivism are in keeping with my personal perspective; I see reality as dynamic and not fixed, interpreted by each individual in a particular social context and fluid over time. I am much more comfortable with constructivist than positivist approaches; grounded theory as an interactionist method fits with both my personal view and with midwifery as an occupation based on relationships.

It is the sociological underpinning of grounded theory, rather than the psychological one of phenomenology, which made it seem particularly relevant to the study at hand (however it is recognised that either of these two approaches could help in the development of useful theory). In addition, the acceptance in grounded theory that the researcher is a social being means that previous experience is a valued source of data (Baker et al 1992). In phenomenology, the data collection process is intended to be free from preconceived notions, expectations and frameworks (Field & Morse 1985) and the researcher is intended to 'bracket' (or identify and suspend) their previous experience and assumptions (Baker et al 1992). This would be very challenging for a researcher who is a member of the researched group and it would also deprive the study of the benefit of 'practitioner knowledge' (to be further discussed later in this chapter). The next section of this chapter will present the details of grounded theory in order to justify the selection of it as an approach for this project.

Grounded Theory

A visiting Australian midwifery researcher provided a useful description of the grounded theory method of qualitative research which both brings to life the concept for me as well as convincing me of its value in my investigation. She (and I wish I remembered her name) used the analogy of the grounded theorist embarking on a research project with an individual entering a semi-darkened room. The task set to the individual is to sort the room out as it is full of things in disarray. The individual starts to pick up things in the gloom and look at them, trying to identify what they are. First, she recognises a hammer and puts it to one side. Then she recognises a rake and places it

in another spot. She begins to realise that all of the objects in the room are in fact tools and, in identifying this, is more able to create purposeful piles of objects, putting together those which have similar functions. After she has been sorting and organising for some time, she looks up from her work. Her eyes have now adjusted to the dim light and she is able to see more clearly the surroundings. She suddenly realises that this is not just any room she is in but a garden shed. Her decision that this is a shed would have been shaped by her previous experience with sheds; it would need cross checking with other definitions of sheds to see if her construct was in keeping with other findings. She would need to look at the shed from the inside and the outside and, having undertaken this rigorous examination, she could draw conclusions about the significance of the shed in relation to the tools therein and help to explain the relationships between these phenomena.

Similarly the grounded theorist begins investigation by gathering data which may seem unrelated and in disarray. "In approaching research without any strong prior theory, qualitative researchers are inevitably faced with the problem of making sense of a vast amount of unstructured data" (Henwood & Pidgeon 1993:21). Glaser and Strauss first described the grounded theory method in 1967 (Strauss 1987) referring to it as theory that is generated in the course of the close inspection and analysis of qualitative data. Since that time, the approach has been widely used in the social sciences and is increasingly gaining popularity in the field of health. Its purpose is to explain a given social situation by identifying the core and subsidiary processes operating in it (Baker et al 1992). The darkened room is interpreted as a shed (social situation) once the tools (processes) in it are examined and identified.

The next three sections of this chapter will discuss, in general, the processes associated with the use of the grounded theory method (specifics, data collection/ analysis/ theory development, and sampling). The actual data collection and analysis methods used within this study will then be discussed in relation to each stage of the project (although the specifics of the personality testing will be presented in chapter eight).

The Specifics of Grounded Theory

"As a systematic way to derive theories that illuminate human behaviour and the social world, grounded theory has many uses" (Chenitz & Swanson 1986:7). These authors suggest that grounded theory is a "highly systematic research approach for the collection and analysis of qualitative data for the purpose of generating explanatory theory that furthers the understanding of social and psychological phenomenon" (p 1). Its strength, then, is in the development of a conceptual framework by which some naturally occurring phenomenon can be made sense of; a problem solving approach is employed to clarify the meaning of social situations. This, however, does not indicate that the grounded theory method aims to reduce all phenomena to simple premises, but rather draws on the complex linkages to capture the variation that characterises the central issues (Strauss 1987). The main features of grounded theory include theoretical sampling and methodological guidelines such as the making of constant comparisons and the use of a coding approach to data analysis (Strauss & Corbin 1990). "The goal of grounded theory investigations is discovery of theoretically complete explanations about particular phenomena" (Streubert & Carpenter 1995:146).

The difference between grounded theory and other research approaches is described by Stern (1980). He suggests that in grounded theory, the theory is induced directly from the data and not from previous studies, although prior research is used in later stages to enrich the categories which are emerging. In grounded theory, processes (as opposed to products or static conditions) are described; each section of data is compared with every other section as part of the 'constant comparative analysis'. Data collection and analysis are undertaken simultaneously; the questions which the researcher asks of the data and the concurrent analysis helps to determine the next phase of sampling ('theoretical sampling'). Therefore a grounded theory study is one which grows as a result of the ongoing analysis; when an interesting feature is elicited, it is tested out on the next sample to see if it remains relevant. The sample can change to be able to explore emerging concepts more fully; selection of subsequent sources of data is based on the questions and answers appearing from the current sample.

There are two main schools of approach in grounded theory, each originating from one of the two founders who, after initial collaboration, went in somewhat different directions subsequently. Barney Glaser and Anselm Strauss first published their

grounded theory approach in 1967. They brought together the social science perspective of recognising the contextual, changing complex nature of reality with the rigour previously associated with the positivist paradigm (Levy 1998). When Strauss and Glaser parted, Strauss continued to develop the method in order to answer any remaining criticisms about the approach. He did this by modifying it from its original concept of emergence to one in which dense codification of data is required, possibly taking the approach in a more positivist direction (Stern 1994). Glaser, however, "favours an alternative, interpretive approach, allowing theory to emerge from the data" by asking 'what if' of the data at every opportunity (Levy 1998).

The combined rigour and flexibility of this approach to research appealed to me as an effective tool to help me on my quest to the development of an educational strategy for learning to be a midwife. The latter approach, that of Glaser's interpretive style rather than Strauss' dense codification, offered the potential for understanding the theoretical base of midwifery more clearly by asking questions of the things which midwives say. The approach seemed one which could rise to the challenge of making 'embedded' theory explicit. Hall & Callery (2001) point out that Strauss, with his subsequent colleague Corbin, made efforts to demystify grounded theory but, in so doing, have developed a more mechanical approach to data analysis with the more technical features of data analysis being given prominence to enhance the rigour of the method. Glaser, in contrast, is felt to have a more intuitive style in data analysis with less focus on the codification process (Hall & Callery 2001) but an emphasis on the constant comparison of data (Glaser 1999).

Using the grounded theory approach, I could collect data from midwives and construct a theory which would represent a 'version of reality constructed from my interpretation of data supplied by the midwives ... participating in this study' (Levy 1998). The theory would be grounded in that data and fulfil the criteria which Glaser (1978) articulated as essential in grounded theories- fit, work, relevance, modifiability, parsimony and scope. Fit relates to the relationship between the core concept and the salient social problem and its ability to account for most of the variation in behaviour to address that problem (Hall & Callery 2001). Work and relevance look at the applicability of the core category to the data and the ability of that core category to work with the other concepts and properties so that most are related to the core one. A core category which fits, is

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relevant, and works, leads to a theory which is dense and saturated with relationships. Glaser (1978) suggests that accounting for as much variation in the data with as few concepts as possible, maximises parsimony (defined in the Oxford Dictionary as 'that no more causes or forces should be used than are necessary to account for the facts') and scope. Glaser's criteria create the image of a concise, well integrated set of relevant concepts which reflect the full extent of the data collected and lead to an overall theory which is meaningful, obvious and helpful to those in the field.

Data Collection, Analysis and Theory Development

The main methods of data collection commonly associated with grounded theory are interviewing and participant observation. But both Glaser (1999) and Strauss (1987) encourage a wide interpretation of the term 'data collection' in grounded theory. Field observation, interviewing, producing videotapes and taping the proceedings of meetings can all produce data; Glaser (1999) includes quantitative as well as qualitative data as having legitimate roles in grounded theory studies. The use of a wide variety of literature sources is also considered appropriate in grounded theory studies, including both the published research reports or philosophical papers characteristic of professional and disciplinary writing as well as biographies, diaries, records, letters, catalogues or manuscripts, which will also provide valuable primary data.

Data collection and data analysis occur concurrently in the grounded theory approach (Baker et al 1992). In order to direct the theoretical sampling, analysis of data must take place as it is collected so that appropriate decisions can be made regarding further sampling. The emerging concepts will determine what information is to be sought next and identify the need to modify interview questions so that the focus of the study develops.

Analysis in grounded theory is usually referred to as coding or the use of 'words that describe the action in the setting' (Hutchison 1986). It represents the operations by which data are broken down, conceptualised and put back together in new ways or the restructuring of the phenomena in order to attach meaningful names to them. This coding procedure persists throughout the data collection and helps the researcher to break through any biases and assumptions which may have been brought to the study.

It is this process which gives grounded theory its credibility through analytical rigour. The process builds 'density' which is perceived to be the essence of sound theory generation. It requires a balancing act between attention to detail and creativity as without the latter, recreation of existing meaning (or putting data back together in new ways) is impossible.

The developing theory is expanded and densified by reduction, sampling of selected literature appropriate to the data analysis thus far, and further sampling of relevant data (Stern 1980). Memos are used throughout to record the theory as it is developed step by step; once sorted, they form the basis of the research report (Corbin 1986). Grounding the theory equates to validating it against the data; there should be clear identification that the phenomena, categories and theory generated come from the data collected and are made explicit from the words and actions of the sources used.

Two criticisms are levied at the grounded theory approach. Morse (2001) questions whether or not culture is considered in grounded theory; in her experience, grounded theory studies can appear to have taken place anywhere in the world as the setting is not necessarily an explicit aspect of the process. She sounds a warning to grounded theorists about the need to contextualise any study; this would also appear to be one of the key differences between grounded theory and ethnography. In addition, Hall & Callery (2001) identify the limitation of treating interview and participant observation data as reproductions of the participants' reality. They identify that both Glaser and Strauss tend to neglect the social construction of that data, especially in relation to the impact of the interviewer or observer. The effect of the researcher-participant interaction on the construction of the data is largely ignored in the literature on grounded theory. Both of these criticisms sounded a note of warning to me; it would be important to identify the context of the data collection and to consider my impact on the participants in the research. I had also put my study more generally in a context by developing an increasing understanding, throughout the project, of the impact of historical developments on midwifery as it is practised currently.

Sampling

Sandelowski (1995) identifies that events, incidents and experiences, not people per se, are the objects of the purposeful sampling of qualitative research. If a phenomenon

is intended to be studied in depth, it is appropriate to choose a sample which reflects the elements to be studied. Therefore selective or criterion sampling begins the grounded theory process. Once initial data collection has been undertaken and themes and categories begin to emerge, the researcher then undertakes theoretical sampling by selecting samples of specific data sources to discover the variations in the situation (Baker et al 1992). This allows for flexibility in that the "emerging conceptual categories direct the future data collection and unforeseen lines of inquiry can be pursued in a way which is not possible with more rigid research designs" (Melia 1982:329). These categories are pursued until they are 'saturated'; that is, that no new concepts are emerging from the data. Size of sample in grounded theory, therefore, is less significant than the quality of data which is collected. Sandelowski (1995:181) identifies that representativeness in qualitative research does not come from statistical frequency but from the fact that data is collected from persons who can stand for other persons with similar characteristics (informationally rather than statistically representative). This will be further considered on the discussion on validity.

Methods Used in the Study

Having considered the background issues in grounded theory, this section will present the specific methods used for collecting data and the approach used for analysis in this study. It will begin with an introduction to interviewing as a data collection tool and will consider issues relating to the interviewing of women and focus group interviewing. The use of narratives as data will then be discussed and the means of interpreting the data from most of this research will be explained (personality testing and the approach used will be dealt with separately in chapter eight). The samples for each stage of the research will be introduced at the beginning of each of the next four chapters so that the participants will be discussed in the context of the stage of the project.

Interviewing

"Interviewing is the predominant mode of data collection in qualitative research" (Antle May 1989:188). There is much discussion in the literature on the process of interviewing and the means by which interviews should be conducted in order to ensure that quality information is generated (for example, Barker 1991; Goode & Hatt, Selltiz, Beeney & Hughes in Oakley 1993). The use of a structured or semi-structured interview questionnaire is advocated by many as essential in order to derive

comparable data. The implication is that, in order for the interview process to be respected as a valid tool of data collection, there needs to be an appropriately professional stance taken by the interviewer leading to the elicitation of responses which will be able to be compared. Mishler (1986) considers this approach as being embedded in the behaviourist model of stimulus-response and questions the assumption. He believes that interviewing is, in fact, a type of discourse and that any attempt to standardise the process through set questions and responses devalues the principal characteristic of conversation.

This study began with individual interviews with fourteen midwives working in an NHS maternity unit in a district general hospital. I wanted to ensure that I would treat these midwives with appropriate respect, that I would effectively collect data which would help in the generation of important theory but also that the experience would be one which was appreciated in some way by the participants. This meant that I could not consider myself as an objective outsider but needed to develop a stance that would allow for interaction without restricting credibility.

Interviewing Women

Mischler's sentiment is supported by a number of feminist researchers (Oakley 1993, Finch 1993, Mies 1993). The hierarchical relationship which is often set up in any interview, with the interviewer having control over the interviewee, is considered unacceptable in feminist terms, as it favours the possible exploitation of the participant. Finch (1993) discusses the moral conflict she experienced when she first started interviewing women, as she found them to be very willing to share personal information with a female interviewer. Oakley (1981) takes the view that formal, survey-type interviewing is not suitable in research of women by a woman (especially a feminist), as the sort of relationship created leads to objectification of subjective experience. Mies (1993) rejects the concept of value free research, of neutrality and indifference towards the research subjects. She suggests that it should be replaced by conscious partiality where the interviewer identifies with the research subjects on a limited basis, which allows for both critical distance and sharing. Oakley (1993) considers that a reformulation of the interviewer role, from being a data-collecting instrument for researchers to being a data-collecting instrument for those whose lives are being researched, is the challenge to be undertaken. She suggests that the traditional

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approach to interviewing where the researcher needs to achieve a balance between being friendly enough to generate a rapport but distant enough to see the interviewee as a "object under surveillance" (Oakley 1993:223) is to be rejected in sociological research with women.

I embraced these principles when starting the research; I wanted to avoid objectifying the participants but rather wanted to converse with them as equals. However I was a novice researcher only having undertaken interviews on one previous occasion. I wanted to make sure that the data I collected would be helpful to the study and not a waste of the participants and my time. I started by using an informal set of triggers or prompts in the first few interviews (this is fully described in chapter six) to help build my confidence and as a means of introducing the interviews to the participants. It proved a useful tool to initiate the conversations and led to the collection of relevant and helpful data.

Focus Groups

In the first stage of data collection with fourteen midwives, these were all individual interviews. As the project moved to the second phase when the midwives I have described as 'autonomous' were interviewed, the interviews were a combination of individual and small groups as a result of the participants' availability. These small group interviews proved a very useful technique, in that discussion was generated which may have been missing from individual interviews. The literature refers to focus groups as particular small group approaches which provide for this important interaction dimension.

> A focus group can be defined as an indepth, open-ended group discussion of 1-2 hours duration that explores a specific set of issues on a pre-defined and limited topic. Such groups consist typically of five to eight participants and are convened under the guidance of a facilitator.
>
> Robinson 1999:905

Focus groups are a method of group interview for collecting qualitative data which have their origins in market research (Morgan 1988, Krueger 1988). Both of these sources indicate that it is a very useful method of group interview. Morgan (1988:12) states that the hallmark of a focus group is "the explicit use of the group interaction to

produce data and insights that would be less accessible without the interaction found in the group". The discussion and debate which is generated in the group can encourage both the personal views within the social context to which the participants belong and a consensus leading to the emergence of clear themes (McDougall 1999). It may be that underlying conflicts are revealed or, even when there is no disagreement, the sharing of experiences and perspectives can provide valuable insight into phenomena (Parahoo 1997). The group participation can stimulate an individual's memories of personal experience; when shared with the group, interpretations by the members help to ground those lived experiences (Roberts 1997). As a result of the shared discussion (and therefore shared responsibility for the issues and concepts raised), focus groups can be considered as 'safe havens' for expressing views or concerns (Sim 1999).

Kitzinger & Barbour (1999) identify a particular strength in focus group research as in the exploration of experiences, opinions, wishes and concerns. Focus group researchers do not ask individuals in the group questions in turn but encourage participation by all members through the exchanging of anecdotes, asking of questions and commenting on each others' experiences and points of view (Kitzinger & Barbour 1999). Wilkinson (1999) suggests that focus groups are compatible with the ideals of feminist research as they are non-hierarchical and a contextual research method.

There are perceived disadvantages with the approach including dominance by particular group members, possible reticence to discuss personal issues in a group or the need to fit in with peers which can lead to a kind of 'group think' (Carey 1995). Bloor et al (2001) believe that focus groups are less suitable than individual interviews when it comes to documenting behaviour as participants may be unlikely to share 'atypical' (or presumably socially unacceptable) behaviours in a group setting. However, focus groups have been used successfully in a variety of settings including sensitive areas like interviewing adolescents about health and sexuality and lesbians about sexual health (Horner 2000, Thomas 1996, Farquhar & Das 1999). These studies demonstrate the use of the approach in potentially vulnerable groups successfully, with some of the disadvantages outweighed by the rich and meaningful discussion produced. Farquhar & Das (1999) point out that the public accounts shared in a focus group may not be the same as the private ones elicited in individual

interviews but that this does not make the findings any less valid. They also confirm that "focus group research has shown that some people may be more, rather than less, likely to disclose or share personal experiences in a group rather than a dyadic setting" (Farquhar & Das 1999:47).

Although focus groups are often used in conjunction with another method of research (once themes are identified in the focus group in market research, the theme may be further explored by questionnaire of a large sample), they may also stand on their own as a source of valuable data (Morgan 1988). The purpose of focus groups is different from other group interactions in that the data produced is of interest to the researcher but there is no attempt to reach consensus, provide recommendations or make decisions among alternatives (Krueger 1988). Mishler (1986:143) suggests that methods of interview can empower respondents and respect their way of constructing meaning, in other words, 'attend their voices'.

In practice, the two group interviews which I undertook proved to be very stimulating. The interaction within the groups (one group of three and one group of five) presented an added dimension to the interviews with lively discussion about many relevant issues in midwifery practice.

Narratives
In both of these first two stages of data collection, the taped interviews that were transcribed provided me with stories from midwifery practice. In addition, the fourth stage of the project, where I asked the autonomous midwives to recount for me critical events which had shaped them as midwives, also provided stories from their lives.

> A story tells more than its tale. It speaks of context and of values. Listeners absorb the story through the web of their own view of the world and by links with their own stories. The tellers reinforce different aspects of their values in each unique story telling. The meanings of stories may be multiple and their embodied social constructs many-layered.
>
> Kirkham 1997:183

Stories or narratives are acquiring an increasingly prominent role as qualitative data sources. The life story of the research participant, whether defined as a 'narrative' or as an 'autobiography' (Harden 2000), offers the researcher the experience of 'living

through, not simply knowledge about' the characters in the story (Greenhalgh & Hurwitz 1999). Emden (1998) suggests that the central tenet to all narrative inquiry is the treatment of the data as stories with the potential to give meaning to people's lives. The validity of the narrative source of evidence is confirmed by Greenhalgh (1999) who claims its rightful place alongside epidemiologic / statistical evidence which is the foundation of the evidence based medicine movement. She affirms that hearing the patient's individual 'story' is as crucial as a knowledge of contemporary research evidence in accurate diagnosis and treatment.

Reason & Hawkins (1998:89) claim that "any event retold from life which appeared to carry some meaning, however small, is a story". They suggest that story and story-telling are the most universal of all expressive media and identify two main purposes, that of explanation and expression. Explanation relates to the classification, conceptualising and building of theories from an experience, and expression allows the meaning of the experience to become manifest (Reason & Hawkins 1998). Bray et al (2000:94) identify that

> While storytelling can initiate the meaning-making process, producing narratives of people's experience, it also provides markers of learning. In the process of telling the story, people realise they have acquired a tacit knowledge about things that previously they would not have been able to articulate.

By asking the midwives to tell me their stories, I have (in effect) asked them to associate meaning to their life experiences and make explicit their theoretical base for practice.

In midwifery, the use of women's birth stories in both practice development and research (Noble 1998/9, Brown 1998, Miller 2000) is making a positive contribution to best available evidence. Listening to the experiences women have shared about their pregnancies, births and early motherhood periods can help midwives to see the implications of their actions. Websites on the Internet now offer women the opportunity to publish these stories readily; unfortunately, how frequently they are accessed by midwives as learning opportunities has not been formally evaluated.

Niemczura (1997) points out that stories told by the birth attendant are less common than those of the woman who gave birth but these are essential sources if there is to be sufficient interrogation of birth as a socially constructed event. To this end, she has analysed stories which have emerged from participation in more than seven hundred births in an American hospital providing important insights from the nurse / midwife perspective. Kirkham (1997) supports the need to listen to midwives stories as well as those of women; "their careful examination may open up new dimensions in which we can usefully be with women" (p.183). Leap & Hunter (1993) told an oral history of midwives in the early part of the last century, sharing the stories remembered by midwives who had practised at that time. Nwoga (cited in Burns & Grove 2001) has studied the stories of African American mothers in guiding their adolescent daughters regarding sexuality; these could be useful sources in helping other mothers to cope with daughters struggling with sexuality issues. These authors are all contributing to an important body of knowledge about using both the care-giver's and care-receiver's stories as means to improving practice.

One of the key issues in the use of stories or narratives, as both research and a practice development tool (Bowles 1995), is in hearing both the facts of the situation and the values displayed by the story teller. The way in which the individual chooses to tell the story, the priority given to particular elements and the conclusions drawn by the narrator all indicate the importance attached to the event. The 'culture of practice' (Lave & Wenger 1991) is demonstrated in the stories which qualified staff choose to share with learners; student midwives will learn a value system by listening to the way the story is told as much as by what is said in it.

There is clearly a strength of feeling that listening to individual stories is an important part of understanding a complete picture. However, the use of narrative may be held with some caution as the interpretation of the story remains with the researcher. Appropriate rigour to deconstruct the discursive practices which shape the story-tellers' subjectivities is required in analysis (Harden 2000). The analysis method would be very important to ensure that the findings were valid; the following section describes the analysis techniques used and the subsequent one discusses the issue of validity.

Analytic Approach

As discussed earlier, analysis in grounded theory is concurrent with data collection and uses a codification process. However, there is a step before codes are defined which would be useful to explore to provide evidence of appropriate rigour in the study.

Reading the Data

Mauthner & Doucet (1998) raise some important points in respect to setting the scene for effective data analysis. They claim that the understanding of one's personal, political and intellectual biography as a researcher, as well as making explicit where one is located in relation to the research respondents, is crucial in acknowledging the critical role the researcher plays in interpreting the data. As discussed in chapter one, undertaking my personal construct of midwifery prior to starting data collection and maintaining a reflective diary as the research progressed helped me to do just that. However the difficulty in reducing bias cannot be under estimated; the researcher has a significant challenge in maintaining objectivity when analysing data. Mauthner & Doucet (1998) suggest that the use of computer programmes in the analysis of qualitative data "confers an air of scientific objectivity on what is fundamentally a subjective process" (p122). In order to minimise the effect the researcher has on the analysis, they describe an approach to dealing with data referred to as the 'voice-centred relational method' Mauthner & Doucet 1998) based on the original work by Brown & Gilligan (1992).

The voice-centred relational method focuses on the repeated reading of the data to identify differing perspectives within. Mauthner & Doucet (1998:125) refer to 'relational ontology' as a "view of human beings as embedded in a complex web of intimate and larger social relations" experiencing interdependence, dependence and independence concurrently within a given context and with various players. These researchers use the voice-centred relational method to translate relational ontology into a data analysis method; they explore the individual's narrative account in terms of the relationships they are experiencing both with other people and their environment. They suggest that the method involves three or more readings of the interview text to identify the differing relationships which the participants are experiencing. Four readings were used in their respective studies; other researchers have used differing numbers of readings to ensure confidence with interpretation of the data. For example, Nadine Edwards used

five readings in her study of women's experiences of home births in Scotland (Edwards 2001). She looked for the plots, the women's thoughts and feelings in relation to themselves and others, their social networks, their acceptance or resistance of the situation and then, finally, the changes which took place in individual women over time (having interviewed women at four points in time during the project). These five readings provided an indepth consideration of the data to ensure the relationships experienced by these women were considered from appropriate and diverse perspectives.

This approach proved invaluable in the interpretation of the data in the first part of my project. In practice, I reread the transcripts several times looking for different issues in each reading. I started with looking for the basic priorities identified by the midwives interviewed, what did they say was important to midwifery? I needed to recognise that what they said was important and what they actually used as their priorities in practice might be quite different. As I was not intending to undertake any participant observations, I needed to be able to look at the data from a variety of perspectives to ensure I did not superficially accept their words as definitive but was able to see beyond.

My first cut through the data resulted in a fairly optimistic picture of midwifery; the ideals of practice were somewhat superficially presented and made life seem quite rosy. There was sufficient evidence to define the issues from their practice which made them feel good and which resulted in positive relationships with women. However, there was also enough evidence that there were challenges in their relations with others in the maternity services to indicate the need for additional readings. My second reading looked at my role in the interviews; were they telling me what they thought I wanted to hear or were they really sharing their realities with me? This reading was to look for me in the interviews and to exclude the sections where I felt I had influenced the participant's contributions significantly. The third reading was to look at the less optimistic side of their stories to identify how and when they felt powerless in their practices. It focused on the negative relationships which these midwives experienced and the impact these had on the care they are able to provide for women. It looked at issues of control, interference and the frustration these caused. The final reading came as a result of discussion with my supervisor, having written up the first draft of the

analysis. She recognised that trust was not described as a two way process in the analysis and felt that another reading would help to see if I had missed an important element of this aspect of the relationship.

This approach to reading was used in the interpretation of the notes from the interviews with the autonomous midwives as well as the records of critical events from that group. It helped to give me confidence that I was using the data as effectively as possible alongside the codification and constant comparative process of grounded theory.

Developing Codes, Concepts and Themes

As described above, all of the transcripts in the first stage of the project were read repeatedly, looking initially for concepts (happenings, events or other instances of phenomena). The different readings helped to define the concepts from various perspectives. Analysis of the interviews began with preliminary coding of passages; this 'open coding' (Strauss & Corbin 1990) encouraged me to break down the data, examine it, compare, conceptualise and categorise it. The labelling of phenomena found in the data led to the grouping of concepts (things which seemed to go together at that point) and the development of substantive codes and then categories, based on how often the concept appeared and with how much importance or intensity. The asking of questions, for example: 'why did she say that?', 'was that response what she thought I wanted to hear?', 'who was the important player in that scenario?', 'how did that affect the relationship?', led to comparison of phenomena. Memos were kept to track the reasoning applied to the analysis; the answers to the questions provided an explanation of how I made sense of the interviewees words (examples of the questions / memos are provided in appendix 3). This process was followed by 'axial coding' (Strauss & Corbin 1990) where the data were put back together in new ways, with new dimensions being considered. This led to the development of new thoughts which required further data collection to test and expand them.

In grounded theory, personal experience is a valued source of data alongside that collected through interview and participant observation, as highlighted earlier in this chapter. The repeated readings of the data enabled me to consider differing aspects and perspectives; my personal experience was also used in helping to interpret the

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words these midwives used. This experience helps the researcher to go beyond the data in the analysis, to consider critically what the participants said and why through the asking of questions and production of memos, to compare the findings to the literature / research evidence and to generate new meanings. The process is iterative with movement between the data, the literature and personal reflection; this enhances the constant comparative dimension of analysis in interpreting the data collected.

My first attempt to make some sense of the enormous amount of data led to me giving these codes and categories titles which seemed appropriate to me. This was challenged by one of my supervisors who suggested that I use the words of the interviewees themselves, things which they said again and again. This put a new dimension on the analysis and allowed me to see more clearly from where the next sample should be selected. It also encouraged me to consider my position as a 'practitioner researcher' (see discussion on page 148) and helped to prevent the 'quantum leaping' in assumption which was a possibility for a researcher so closely involved in the subject being researched.

The data collected in this project are extensive as is common in qualitative research. In the early phases of analysis, all of the data collected to that point were considered and catalogued. The potential paths of further enquiry were determined through the codification process; this inevitably left some of the data aside as it was not the common or majority experience. Murphy et al (1998), in their extensive review of criteria for assessing qualitative research, highlight the importance of the careful study of 'deviant' cases, or those that are inconsistent with the emerging analysis. This allows the researcher to refine the analysis until it is possible to integrate all or most of the available data. They report that authorities on qualitative methods stress the importance of including 'negative or exceptional instances' in the research report to add weight to the truth of the claims of the project (Murphy et al 1998:190). Therefore, following the initial analysis, I subsequently included divergent comments in the discussion to strengthen the emergent themes. For example, in the discussion about managing women's expectations in chapter six, one midwife articulates the fruitlessness of feeling that giving is a competition; although this was a somewhat 'deviant' comment, it was used to strengthen the point about realistic preparation for birth. The deviant data also informed the general discussion around the concepts and

themes to provide bases for comparison, contrast and critique. Perakyla (1997) proposes that researchers should not consider deviant cases as a nuisance but as a treasure, as analysis of deviant perspectives can help to add "impetus, strength and rigour to the development of the analytic arguments" (Perakyla 1997:212).

Initially I undertook the analysis manually. This involved highlighting passages in the transcripts with the initial codes and writing memos in the margins on printed copies of the transcripts. I then cut and pasted the coded areas on a personal computer to group the initial codes together. This provided the opportunity to see if the concepts which seemed to be emerging were dense enough, that there was sufficient data to support them. In so doing, I was able to discard some of the initial codes and create new, substantive and more appropriate ones which fitted the issue more closely.

Having had the opportunity to attend a two day workshop on using a computer-based qualitative analysis package at a later stage, I returned to my interviews and started to re-analyse them using N5 QSR. Despite the criticism raised earlier by Mauthner & Doucet (1998), that use of computer packages may try to confer an unrealistic air of scientific objectivity, I embraced this as an opportunity to revisit the data rather than as a replacement for the manual analysis already undertaken. This involved beginning again with the transcripts from scratch; I created 'free nodes' (codes) and grouped these into categories in the computer package. Inevitably the outcomes were similar to the first analysis but there had been a time-lag from the initial process to this second one. The delay allowed me to look at the data with 'fresh eyes' and led to the confirmation of some of my initial codes and categories but also provided new insights. I found the use of the computer package somewhat limiting however. If I wanted to try to regroup comments under different headings or to sift the data in a different way, the need to recode the data each time proved quite cumbersome. Therefore, once I was happy with a coding system, I resorted to manually establishing categories and themes (see appendix 4 for the evolution of this process). This re-analysis was a very valuable exercise in ensuring the appropriate rigour had taken place in the analysis and provided me with considerable confidence in the process.

Validity

Lincoln & Guba (1985) claim that the issue in any qualitative research is not whether another investigator would discover the same concepts to describe or interpret the data but whether the findings of an inquiry are worth paying attention to. In the case of grounded theory, the validity of the research is best tested through the usefulness of the theory generated (Baker et al 1992). Similar to Glaser's criteria, Chenitz & Swanson (1986) explain the concepts of 'fit', 'grab' and 'work' in relation to the validity of grounded theory. These relate to whether the theory is credible; it must 'fit' the phenomena under study or be readily applied to the data and categories generated, it must 'grab' or be relevant to the social or practice world and to persons in that world and it must 'work' or be useful to explain, interpret and predict the phenomena under study.

The notion of validity in qualitative research is widely discussed in the literature. The necessity to incorporate rigour with subjectivity and creativity into the scientific process present significant challenge for the qualitative researcher (Johnson 1999). Sandelowski (1993) suggests that the inflexibility and rigidity of rigour can threaten the artfulness of qualitative research, including the sensitivity of meaning, which is essential to the methodology. The need for creativity is required to support the discovery of the 'not yet' known, going beyond established knowledge and to challenge accepted thinking (Marshall 1990); however this cannot be done at the expense of quality.

The term validity has its roots in the 'reliability' notion of quantitative research; this refers to the stability of findings, the possibility of replicating the study in another time or place and arriving at the same conclusions. Whittemore et al (2001) claim that validity represents the truthfulness of findings; the difference in terminology appears to highlight the differing tenets of the two paradigms. The term 'validity' has been interpreted in a variety of ways by those aiming to articulate an appropriate definition to fit the qualitative paradigm - truth value or credibility (Lincoln & Guba 1985), trustworthiness (Eisner 1991), authenticity (Guba & Lincoln 1989) and goodness (Marshall 1990). However, Whittemore et al (2001) recognise that none have been overwhelmingly supported; the semantics of language may have overtaken the

purpose of the discussion which is to articulate a mechanism to ensure scientific rigour.

The validity of my research has been tested throughout the project in a number of ways. I have discussed my findings and thoughts with both of my supervisors, a number of active researchers in the field and professional colleagues. I have presented aspects of the project in a number of fora - twice at the university's annual MPhil/PhD Conference, two seminars on the results of the personality tests with midwifery and psychology colleagues and issues from the literature searching / analysis at external conferences.

My reflective diary records how many other sources were used informally in making sense of the data collected for this project. As a teacher, I regularly meet with both student and qualified midwives in practice and classroom sessions. When a new point occurred to me in developing the themes, when appropriate, I would test it out with a group to see if there were different ways of understanding the situation. This almost implicit dimension of the project cannot be effectively documented but contributed significantly to its development.

Ethical Considerations

Before beginning data collection, I sought ethical approval from the committee at the institution where I planned to collect data. A district general hospital, with a maternity unit which provides for approximately 3000 births per year and situated in a suburban area of London, was chosen as the main source of initial participants. This choice was based on a number of factors. This maternity unit is perceived by local midwives as a fairly non-interventionist unit, where obstetricians do not dominate practice significantly, thus providing the opportunity to talk to midwives who practice with reasonable autonomy. Midwives undertake two approaches to practice in this unit, the majority being in 'teams' of midwives who provide continuity of care for women (as discussed in chapter three) and a minority in the 'core' of midwives who staff the clinical areas in the hospital. This approach might provide for some comparison between the experience of these two patterns of practice. The final reason was that the Head of Midwifery was happy to agree that I undertake the study in the unit.

I had planned in the research proposal to undertake three areas of data collection (although it was recognised that these may change as categories emerged); these included individual interviews with midwives, focus groups with women and participant observations with midwives in practice. I approached the Local Research Ethics Committee for approval to conduct the first three parts of the study in both the maternity unit and the local community. I very quickly received approval to interview midwives but there was hesitation about the focus groups with women as the Committee felt that "unstructured group discussions shortly after the birth of the child could raise fears and anxieties within women at quite a vulnerable time. This was felt to be particularly the case where a mother who may have had a bad experience of labour would then be in a situation of discussing the role of the midwife during labour and concern was expressed as to how such situations would be dealt with."

These concerns were welcome as it indicated that the committee was really considering the possible impact of the experience on women. My reply to the issues which were raised included: the fact that my plans were to interview woman at three to six months postnatally and therefore at a time when they would have had the opportunity to debrief and work through emotions, that I am a very experienced midwife and have dealt with women who are unhappy after childbirth many times, and that I had previously conducted focus group research with adolescents (also a possibly vulnerable group) looking at their understanding of the relationship between sexual activity and health. I assured the committee that all participants in the research would be invited to attend and could opt out at any point should they choose to and that both confidentiality and anonymity would be guaranteed. This appeared to allay the fears and approval was granted for all three aspects to be conducted in that maternity unit and community. However, as data collection progressed, I only undertook two such interviews and then felt that interviewing women was not a source I needed to pursue.

Issues to Consider in the Study
Practitioner Research
Reed (1995) examines the role of the practitioner in researching her / his area of practice. Obviously, as a midwifery lecturer who practises regularly if not frequently these days, I bring to this research a large body of professional knowledge and understanding. In the positivist construct of research which aims to 'scientifically' and

objectively examine a phenomenon, it might be considered a disadvantage to be closely involved with the area of study. My experience, values and attitudes might be thought of as a distraction which could intrude on my ability to clearly see and hear what midwives are telling and showing me. The value of the research could be questioned by those steeped in the quantitative approach believing that paradigm to be free of the impediment of prejudice and preferable to a study undertaken by a potentially biased member of the group being studied.

Reed (1995) dismisses this concern on many accounts; she suggests that "research is done by people and to understand, it is necessary to understand the people who create or construct it" (p46). There is a positive advantage to being a member of that group because the language used, activities undertaken and guiding principles are a part of the researcher as well as the researched. However the possibility of both choosing a biased sample and making quantum leaps in analysis cannot be ignored.

> A qualitative researcher requires theoretical and social sensitivity, the ability to maintain analytical distance while at the same time drawing upon past experience and theoretical knowledge to interpret what is seen (*and said - my addition*), astute powers of observation and good interactional skills. Possibly the most important issue to keep in mind is that the challenge to the researcher is to pay attention to detail which may well generate new insights rather than simply perpetuating her existing views of practice.
>
> Strauss & Corbin 1990:18

This suggests that any researcher is an integral part of the investigation with an intimate role to play. In a discussion on the anthropologist working at 'home' rather than in a remote or foreign culture, Van Donegan & Fainzang (1998:247) highlight that "just as distance is not a guarantee of objectivity, familiarity is knowledge". The proximity of the researcher to the project, regardless of the environment in which it is set, challenges every researcher to consider her / his objectivity. Coming from outside the context provides no guarantees of objectivity any more than being from within ensures true understanding. Possibly the most important issue to keep in mind is that the challenge to the researcher is to pay attention to detail which will generate new insights rather than simply perpetuating her existing views of practice.

Chesney (2001:127) identifies that researchers are 'exhorted to neutralise or hide themselves behind a veil of objectivity' in a research project, to avoid personal engagement either in data collection or analysis. If the researcher becomes too involved, they may over-identify with the subjects leading to 'tunnel vision and flawed and limited findings' (Hammersley & Atkinson 1995:98). However, this aim for neutrality and objectivity may, in fact, be both impossible and undesirable. It would seem unlikely that any researcher wholly committed to a project would be unaltered by it. Chesney (2001) shares the impact that her participant observation had on her, how she changed as a result of being a researcher. This must mean that she was very involved with the research, that it had both meaning and importance to her. But this involvement does not necessarily mean subjectivity and therefore 'flawed and limited findings'; it means that she cared about the women she was interviewing and needed to feel engaged with them. She reports that she gained confidence as a researcher as the project progressed, became prepared to be different from the popular theoretical opinion, able to feel safe to expose herself as an active player in the project rather than a covert spectator.

This discussion relates to the issues of interviewing women raised on page 135. There are advantages to being a member of the group being researched - a woman, a midwife. But the ability to clearly identify what you found, how you found it and what it meant to you, and to articulate it meaningfully for others to see, should negate most concerns about closeness or involvement. This challenge remained with me during this project and I attempted to address it in a variety of ways. Firstly, I continued to document personal reflection throughout the project as a means to comparing and contrasting my perspective with the data collected. Secondly, I used both my supervisors and other colleagues as 'sounding boards' to test whether I was truly using the data to generate newly identified concepts rather than reinforce my own thoughts. Thirdly, I have made explicit, to the best of my ability, the connections which I make in the data so that readers (from both within and without the profession of midwifery) can clearly see the analytic processes undertaken.

Limitations

As in all research, there are limitations to this study. As raised earlier in the discussion about 'readings', it seemed to me at times in the interviews with the initial midwives,

they sometimes gave me answers that they thought I wanted to hear. This is obvious in some of the words of the midwives presented in the analysis. (Although I don't work in the maternity unit where the research was undertaken, it is likely that I am known by the majority of the midwives interviewed by reputation if not in person.) However, in the descriptions the midwives gave of scenarios from practice (their stories), their words often gave me a different perspective which, I believe, tells it 'like it really is'.

As this is a relatively small qualitative study, it could be argued (and has been in the past in similar ones) that no generalisations can be made from the findings. Morse (1999) is starting to challenge the belief that qualitative studies are not generalisable (and indeed suggests that they would be meaningless if that was the case). She points out that the generalisability of qualitative research is different than that of quantitative; the purpose for both is to generate new theory but the means by which this occurs differs. In quantitative studies, the sample size and random selection is intended to ensure findings representative of the entire population of interest. In contrast, the relatively small sample in qualitative research cannot make the same claim but the fact that the sample is selected (as opposed to random), on the basis of the particular contribution which can be made to the emerging theory, could increase its generalisability. The findings will be based on a purposeful sample, members of which had a specific and relevant contribution to make to the study. This selective sampling leads to theory development which is comprehensive, complete and saturated. Morse (1999) presents a persuasive discussion which suggests that qualitative findings may be significantly more generalisable than quantitative ones.

It cannot be suggested that the issues raised would necessarily be the same had the research been undertaken with a different group of midwives and by a different researcher. Regardless, the things that these particular midwives shared with me are important and have helped me to consider a direction for curriculum planning and midwifery education which may have a significant impact in the future.

Conclusion

Theory underpins all practice; in order to be an effective practitioner, one must have knowledge and understanding as well as skills. The use of this knowledge and understanding will be influenced by one's personal theoretical framework which

includes the values, beliefs and philosophical stance of the practitioner. The value base to practice is an area which is often implicit in the practitioner; this project intends to try and elicit some important concepts from the value base of midwifery in order to inform the education of prospective practitioners.

Grounded theory has been chosen as the research method to be used in this study; however, the data collection approaches used are somewhat more diverse than those described frequently in the literature (i.e. including personality testing). In order to present the research process clearly, this chapter has related to overarching issues including theory generation, methodology, and the specifics of grounded theory. It has also described the specific data collection processes and analytic approaches used in all stages of the project with the exception of the personality tests, which will be covered in chapter eight. The issues of validity, ethical considerations, issues of practitioner research and limitations have been raised and considered in the context of this particular study. Evidence has been provided of the rigour of the research methods used in the study which should provide the reader with confidence in the findings to be presented in the next four chapters.

Question One - What is unique about midwifery which students must learn?

Introduction

This chapter will present the findings and analysis of the individual interviews undertaken with fourteen midwives in a district general hospital maternity unit. It will begin with a discussion about the data collection method used, move to a description of the individuals interviewed with the context of their employment, identify the specific approach used to analysing the data and will then proceed with the themes which emerged from the analysis of the data collected. Relevant literature will be used to inform and debate the concepts in the themes throughout the discussion.

Data Collection

Interviewing Approach

With the important considerations about interviewing women discussed in chapter five in mind, I approached the individual interviews with midwives as an opportunity to hear about their reality in practice, their perceptions of the key issues and concepts in midwifery. I wanted to be seen as the stimulator of discussion rather than as the leader of the interview. At the beginning of each interview, I asked for some basic demographic detail and then, in the first four interviews, I used some trigger questions to generate discussion in order to help both the interviewee and myself to feel comfortable. These questions came about in a brainstorm with my supervisor and two other researcher colleagues; they were intended as a starting point, making no attempt to impose any sense of priority or preconceptions about midwifery.

Interview Prompts

Background Information
Age
Where born?
How long a midwife?
Where and when trained?
Direct entry or post nursing?
Experience as a midwife - where and for how long?

Area of practice now?
Anything else?

<u>Trigger Questions</u>

Please imagine that I am an American who has never encountered a midwife
before. I really don't know what it is you do. Can you please explain your role to
me?

Tell me about a birth which really made you feel like a real midwife. Why do you
think it made you feel that way?

Have you had any relationships with women recently which you would describe as
really special? What made them special?

Can you think of a time when things didn't go as you would have liked, where you
were unhappy with the outcome? Can you tell me why you think you felt that way?

What does the word 'normal' mean to you?

Can you explain what about your job gives you satisfaction?

What made you go into midwifery?

What do you think are the differences between nursing and midwifery?

How do you feel about being a midwife?

These questions proved helpful in stimulating discussion although they were not
adhered to strictly but used as a focus for the discussion if there was a pause in the
midwife's flow of conversation. In view of the earlier discussion about interviewing
approaches, I believed that I should interact with the interviewees and embrace the
developing relationship rather than trying to objectify it. Oakley's thoughts on the way
forward for feminist methodology guided me:

> It requires, further, that the mythology of 'hygienic' research with its accompanying
> mystification of the researcher and the researched as objective instruments of data-
> production be replaced by the recognition that personal involvement is more than
> dangerous bias- it is the condition under which people come to know each other
> and to admit others into their lives.
>
> Oakley 1993:242

I tried to set a comfortable context so the midwives felt able to talk easily to me; in
most cases, this was very successful with the participants freely discussing their
thoughts and experiences.

Once the first four interviews were complete, transcribed and initially analysed, I continued to use the trigger questions but supplemented them with some themes which seemed to be emerging to stimulate the discussion with the next four interviewees (for example, normality, trust, teaching women, control, continuity). Similarly, after the second four were complete, I proceeded with another four having done initial analysis. I did not use all of the trigger questions at this stage, other than the invitation to share positive and negative experiences, but focussed on more specific issues emerging (safety, trust, continuity, risk, normal / abnormal, guilt, control) to test out the themes from all previous interviews. On completion of the third set of four interviews, there were few new issues emerging so I did a final two interviews at that stage, to test out the emerging concepts, before moving to the next phase of the project.

The Context

The interviews took place, as described in the previous chapter, in a district general hospital. The structure of the maternity service had two main spheres - team midwives who provided continuity of care to defined groups of women and core staff who worked within the hospital to provide a service for women who did not live in the area or for when team midwives were not available. As discussed in chapter three, team midwifery was first described as an approach to maternity care by Flint et al (1988), where a small team of midwives provided continuity of care through pregnancy, birth and the puerperium to a defined group of low risk women. In this service, the team midwives provided support to groups of women in all risk categories, providing continuity from a small group of midwives (approximately six) to a geographically defined caseload of women. The approach was not one of caseloading where individual midwives relate to individual women; continuity of care rather than carer was the emphasis. The experience of these team midwives was likely to have some distinct differences from those working as core staff in the maternity unit, especially in respect of the relationships they were able to develop. However, it seemed important to get the perspective from both groups as the study was about midwifery issues in general and continuity schemes are still not the norm in the British maternity services.

Therefore, the sample was from both team (seven) and core (five) midwives and also included one midwifery manager and one link lecturer. The lecturer was employed at a

nearby university; she visited the maternity unit on a weekly basis both to support student midwives and to maintain her practice and so regularly cared for women in the unit. The sample was self selecting and therefore the numbers from each area of practice were not specifically planned.

As I was working at the university local to this maternity unit (as the Head of Midwifery Education), I was known by some of the midwives in the service. I think this helped in finding volunteers to participate in the project as I was not seen as an unknown outsider. It certainly helped in getting agreement from the Head of Midwifery to undertake the study in the unit (as was raised in chapter 5; the specifics of access to this maternity unit are included in this chapter as they are only relevant to this section of the study). I was invited to a few team meetings to discuss the research as a means to eliciting interest in participation. In addition, I prepared notices to go up in the unit describing the project and asking for midwives to contact me. Initially there were a number who expressed interest; once the initial group had been interviewed and no others were forthcoming, the midwifery managers were helpful in passing the message on to more midwives to find further volunteers.

It is difficult to determine exactly what effect being known by some of the midwives in the service may have had on the volunteering process. It may seem likely that only those who are particularly confident would put themselves forward to participate in such a project; however this did not appear to be the case as the participants varied in their experience and their projected levels of confidence. I provided the participants with an introductory letter at the beginning of the interview; this provided a basic explanation about the purpose of the study, stressed anonymity and confidentiality and provided an opportunity for the midwife to choose not to participate if there were any last minute anxieties. All were happy to proceed once they had read the letter. A number did ask about the final outcome as they were interested in learning how the project developed and its effect. I offered to make sure that a copy of the completed thesis was made available in the maternity unit, recognising that it was likely to take some time.

All but one of the interviews were undertaken within the maternity unit; I offered the participants the opportunity to choose where they would feel most comfortable,

including meeting them off site should they feel that was preferable. The one interview off site was in the midwife's own home in the evening. Those which took place in the unit were undertaken in a variety of places, dependent on where the midwife was working and where there was an empty space. Five interviews were conducted in a seminar room adjacent to the team midwives' office, five took place on the delivery suite in the office or in an empty labour room, one in an office in the antenatal clinic and one in a day room on the postnatal ward. There was always an attempt to find a quiet location but there were interruptions in some of the interviews with other staff coming in looking for someone or something. These interruptions did not have a substantial negative effect; they were generally brief and we were able to pick up the discussion where it had left off quite easily in all cases.

The midwives generally spoke easily and freely with one exception. In this interview, the midwife appeared to feel there was a 'right' answer to the questions I raised to stimulate discussion. Although I tried to reassure her that the intention was only to hear of her experience and thoughts, it was probably the least satisfying interview in that she was brief in her replies and appeared to feel quite self conscious. I could not escape the possibility that some of the interviewees may have felt intimidated or restricted by who I was. It did not appear to influence their ability to discuss issues and to tell me their stories in the main but there was, at times, the feeling that they might be telling me what they thought I should hear. It must also be recognised that what the midwives told me and what they actually did in practice could be two quite different things. With the beauty of hindsight, participant observation may have added strength to the data collection in this stage. However, learning of their ideals as well as real experiences from their practice was very important; the 'what they thought I should hear' would give me insight into their priorities and passions about midwifery which would be very valuable, even if not achievable on a daily basis. It was important in the analysis to consider this balance between 'real' and 'ideal' and to look at their interviews both as whole conversations as well as considering the codes within, to get the overall impression. All of the transcripts included substantial passages which shared personal experience, and appeared to describe the perceptions of situations in such an honest and open manner, that I feel there is ample data from which to draw which reflected both their dreams and their realities.

Having spent large amounts of time with the transcripts over the past few years, I can see that I became more effective as an interviewer as I undertook more interviews. Generally I spoke less during the later interviews than the earlier ones; I was able to describe a theme which was emerging and provide a useful trigger for the interviewee to expand on and within which to share relevant experiences. The interviews lasted between forty and sixty minutes each; in one interview the tape ran out so I was only able to transcribe the first twenty five minutes (part of my learning curve!). At the end of each interview, I left the maternity unit and went to a quiet environment so that I could write up my notes about the environment, how the interview had gone, any key points which may have been lost if the tape hadn't recorded the comments clearly and my feelings about the interview as a whole. These comments are recorded in my reflective diary which has been an important source of identifying my learning through the project.

I met the interviewees at differing times of the day and days of the week to fit in with their individual situations. A few of the team midwives asked me to meet them at the beginning of their day, first thing in the morning before they got caught up in their work. I went in on the weekend to do two of the interviews on the delivery suite; I called first to make sure the unit was quiet. These were particularly successful in that there were fewer disruptions and little feeling of pressure on time. Others I met at lunchtime or the end of a shift to try and provide space within their busy lives to enable a relaxed discussion. At the beginning of each interview, I suggested that the interview could last as long as they wanted it to but that up to an hour would be a reasonable estimate.

The Interviewees

This chart provides demographic information about the fourteen midwives involved in this phase of the project:

Initial Midwives

Participant	1	2	3	4	5	6	7
Age	31	29	49	34	32	39	31
Trained	Scotland	London	London	London	London	London	London
Qualified	1989	1993	1970	1992	1992	1982	1992
Area Of Work	Teams	Teams	Teams	Teams	Core (ANC)	Core (D/S)	Core (D/S)

Participant	8	9	10	11	12	13	14
Age	37	27	27	35	44	40	42
Trained	London	London	Surrey	Yorks	Oxford	London	London
Qualified	1982	1995	1992	1986	1977	1978	1978
Area Of Work	Core (D/S)	Teams	Teams	Manager	Lecturer	Teams	Core (P/N)

ANC = Antenatal Clinic

D/S = Delivery Suite

P/N = Postnatal Ward

All of the interviewees were women; all had trained first as a nurse and then moved into midwifery. The majority had trained and practised midwifery locally although none had been born in the area; seven were born elsewhere in England, six in Ireland and one in Malaysia. The teams were still relatively new in the service at that time, so the team midwives had all only been practising in that way for less than one year. One of the midwives on a team was a very experienced delivery suite midwife who was doing a secondment to the teams; she was very positive about the continuity scheme but did find it more demanding in terms of time and personal energy. The core midwives came from a variety of areas - one from antenatal clinic, one from the postnatal ward and the other three from delivery suite. The manager had responsibility for the Community Midwifery Service including the teams. As discussed, the lecturer was from the local university and she practised within the unit on an occasional basis as well as regularly visiting the unit to support students while gaining practice experience. There was twenty five years difference of the length of time in practice between the most and least experienced of this diverse group of midwives.

Analysis

Each of the interviews was transcribed verbatim; two by a typist and the other twelve by myself. I did not find it as satisfying having the transcripts typed by someone else; by the time I had listened to them again and again while typing those I did myself, I felt

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very aware of the issues raised in those interviews. As a result, in addition to reading the two transcribed by the typist a number of times, I listened to the tapes again a few times to gain the same level of familiarity. I chose not to have any further interviews transcribed but resorted to the slower but more meaningful method of transcribing them myself.

All of the transcripts were read repeatedly, looking initially for concepts (happenings, events or other instances of phenomena). As discussed in chapter five, the repeated readings were done for different purposes to ensure the data were considered from a variety of perspectives. Analysis of the interviews began with preliminary coding of passages; this 'open coding' (Strauss & Corbin 1990) encouraged me to break down the data, examine it, compare, conceptualise and categorise it. The labelling of phenomena found in the data led to the grouping of concepts (things which seemed to go together at that point) and the development of substantive codes and then categories, based on how often the concept appeared and with how much importance or intensity. As described in chapter five, the process included the asking of questions, recording of memos (see appendix 3) and then 'axial coding' (Strauss & Corbin 1990) where the data were put back together in new ways, with new dimensions being considered. This led to the development of new thoughts that required further data collection to test and expand them. The analysis was undertaken initially manually and then repeated at a later stage using the NVIVO computer package; a demonstration of the development of the codes, concepts and themes is found in appendix 4.

Findings

In this section, the codes, categories and themes which have emerged from the data will be presented and explored, using literature to develop discussion regarding their significance. (The quotations from the midwives interviewed will be identified by number, indicating the order in which the interviews took place. Their words are italicised for easy identification.)

Codes	Categories	Themes

Relationship
Friendship → Building a rapport →

Getting to know each other
It's easier → Continuity → Making a difference

Special effort → It was special →

Advice
Teaching → Knowing what to expect → Preparing

Feeling safe/ trust
No interference → Feeling in control →

Making sure

Guilt
Interference
Playing God → Not feeling in control →

Making a Difference

Relationship
Friendship → Building a rapport →

Getting to know each other
It's easier → Continuity → Making a difference

Special effort → It was special →

This theme comprises three categories, that of 'building a rapport', 'continuity' and 'it was special'. These three intertwine but appear to have distinct issues relating to each; they come together as all contribute to ways in which midwives can make a difference

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with and for women. They all relate to midwives connecting with women beyond the physical support and care required in pregnancy, labour and birth.

<u>Building a Rapport</u>

The need to establish a relationship with women was a priority for many of the midwives interviewed. It was considered a very important starting point in the midwife / woman interaction and one of the prime undertakings when meeting a woman for the first time.

4: "Obviously meeting them and beginning to build up a rapport with them"

The discussion with a number of the midwives included the communication skills required to build this rapport, the importance of reducing fear of the unknown through the relationship and the dividing line between professional relationship and friendship. Other important issues came up alongside that of developing a relationship, for example, continuity, trust and control. Continuity will be discussed in this theme of 'making a difference' but trust and control are explored in relation to other categories / themes where their significance appears more relevant.

The comments about building a rapport are more prevalent in the earlier interviews when I was asking the participants to talk more generally about midwifery. In the later interviews, I was testing out different emerging concepts; in these, the issue of relationship was often implicit but less explicitly expressed.

Relationship

> The relationship that develops between the woman and the midwife is at the core of human caring and may provide the basis of the professional body of knowledge that encapsulates midwifery.
>
> Siddiqui 1999:111

The midwives interviewed referred implicitly and explicitly to the importance of this dimension of their work. One midwife described the process of building a relationship as part of the list of things to be done when you first meet the woman, alongside taking her blood pressure and listening to the fetal heart. She identified it as a fundamental part of care.

6: "There are certain things that you have to do like checking her over. That is routine, blood pressure, temperature, urinalysis, listen to her baby. And you actually build up a

rapport with her and you get to know her. Firstly as a patient and then as a person. I think that's important- getting to know her."

This interesting distinction between a patient and a person may suggest that there are two levels in the relationship - the functional one where it is important to get to know about the pregnancy or the woman's physical condition followed by a more interpersonal interaction. This distinction was identified by another midwife who clearly felt that the interpersonal aspect was the more important one.

7: "You do the physical stuff that you have to but it's more than that. They learn to trust you, you build up a rapport when you are looking after them and they trust you."

This distinction emulates the two roles described by Wilkins (2000) in her study of the relationship women have with their community midwives, referred to in chapter three. She found that women valued significantly more the 'special relationship', in which there is personal and emotional engagement between midwife and woman, than the narrow professional one in which the woman is objectified and the relationship is functional. The function of the relationship in the professional paradigm (as discussed in chapter two) is to provide a service but that service is framed by a "discrete body of knowledge and expertise divorced from the social and relational context of its application" (Wilkins 2000:33). This paradigm limits the interpersonal dimension of the midwife - woman relationship; Wilkins claims that it is "the human relationship rather than merely the service or skills that is valued (by women)" (2000:33). The process is as important if not more important than the product; women and midwives interact in more than just a professional sphere. Both are people with emotions, hopes, needs and fears and Wilkins identifies an "emotional connectedness across the professional - client divide" (2000:37) which can exist between the midwife and woman. In exploring the role of the community midwife, Wilkins describes a much closer, more personal relationship between the woman and the midwife than with other care-givers such as general practitioners and health visitors, both of whom are considered to have professional rather than personal relationships with women.

One benefit of connecting with women was referred to, by one of the midwives interviewed. She identified that she could be more effective if she had the opportunity to build a relationship.

2: "I think that a lot of midwifery is feelings that you have, that you build up relationships with women and I think that sometimes you just know when things are wrong; at least I do, anyway."

This comment pulls together the value of the two dimensions already identified. It alludes to intuition or the ability to just 'know about' something untoward as a result of an established relationship. The relationship may start with reviewing physical aspects of the pregnancy and go on to more personal issues. However, once established, the relationship can play an important part in helping the midwife to determine deviations, as the midwife knows the woman and understands her usual state or behaviour. Edwards (2000) found in her research with women planning homebirths in Scotland that women defined their need for support from a holistic viewpoint; they wanted both physical and emotional support from the midwife. However a number of women in this study identified the priority of the midwife in pregnancy as doing the physical 'checks' rather than in developing a supportive relationship. When a bond was formed, the midwife was seen as 'being on the woman's side' (Edwards 2000:68), as identified in the section on relationship in chapter three. This bond was highly valued by the women who experienced it, as was the case in Wilkins' research, referred to earlier. These studies suggest that priority may be given by some midwives to the physical aspects of care but the real benefit to the women, in those research projects, was when the relationship was more personal. The midwives in this study corroborated the value of an interpersonal rapport between midwife and woman.

When there has been no opportunity to build a relationship with a woman before labour, the need to be able to bring this about quickly in the labour situation, to be supportive and help to reduce fear, was expressed.

10: "You introduce yourself, ask them questions, make them feel comfortable and try to make them feel they are welcome; help them to overcome their fears. A lot of women come in here very frightened, literally, especially if they are core patients who have not met the midwives before. They don't know us and you just have to build up a relationship in a very short spell of time."

8: "People who come into a building, they haven't been there before. They are in labour, they are vulnerable, so you have got to try and take that vulnerability away from her. I think you do that by listening to her, being with her and appropriately talking to her. It's no point talking with her when she's got a contraction, she can't hear you. So you have got to sort of take that vulnerability away from her, you have to listen to her. If

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she's not feeling like she's being listened to, you've got to be with her. It's no good going in and out of the room."

Nicky Leap (2000) identifies the challenge of being thrown together with a 'labouring woman whom you have never met before, you work hard at building rapport and gaining her trust'. This issue of trust is clearly important to women during labour; the midwives interviewed emphasised the need to reduce the woman's fear and sense of vulnerability. The importance of the woman having faith in the midwife is explored in Anderson's study (2000b) of women's experiences in the second stage of labour. These women wanted to feel safe enough in the hands of the midwife to be able to 'let go', to know they would be safe at a time of intense sensation and somewhat altered consciousness. While they were busy concentrating on the hard work at hand, they wanted to know that the midwife would protect them. The midwives interviewed agreed that it was their role to provide this protection (to be further considered under 'making sure') but also identified the difficulty if a relationship had not been formed prior to labour.

The value of the opportunity to get to know women in advance of labour was recognised by one midwife who was on a team and one who was not.

4: "I mean she knew me and I knew her family and that was very good. Rather than coming in and not knowing her, we'd already built up a rapport and she seemed to trust me and she did end up with a nice normal delivery."

6: "We are short handed in the labour ward, so it would be ideal if in the antenatal period, that rapport is already there. But when they come into the labour ward, it's different. Sometimes with the core themselves, they need that little time to get to know them, that's why it's important to stay with them."

The issue of physically being with the woman, staying with her, was considered very important and the pressure of work, which prevented it from always being the case, caused frustration.

6: "We are short handed on the labour ward... I was upset because I wanted to stay with her but I couldn't, I had three other women in the mean time... I was very unhappy."

7: "Quite often we are short of staff, you feel you can't give- I mean physically you can't do it... I felt bad because I had to leave her. I couldn't be with her in labour. I had to

pop in and pop out, pop in and pop out. I kept apologising to her and then the other woman I was with, I kept apologising to her. It just was not on, do you know what I mean? I find it very frustrating."

These midwives felt uncomfortable with not being able to provide continuous support in labour. In a systematic review of intrapartum support in labour (eleven trials in a variety of different cultures and contexts of maternity care), it was found that the continuous presence of a trained support person (not necessarily a professional but someone with an understanding of the birth process like a doula) reduced the likelihood of several negative outcomes. These included medication for pain relief, Caesarean birth, lower Apgar scores at 5 minutes, increased length of labour and negative ratings of the childbirth experience (Hodnett 1997). However, in the maternity unit where the research took place, there are often insufficient core midwives on duty to be able to provide one to one support for women in labour who are not on the team scheme. This feature, especially for the core staff, impacted on their ability to develop a supportive relationship and rapport and the satisfaction with the care they were able to provide.

Friendship

Some of the midwives interviewed said that they thought of the relationship with women in their care as a friendship:

2: "the relationships that I build up with the women and their families and the feeling of being a friend rather than a nurse or a carer; I am a carer but it's different, I'm on a level with them and they're... I'm almost a friend or an advocate for them ..."

8: "I would say it is a friendship, I like to think of it for that particular time."

The concept of friendship, however, is restricted by these comments in that the first midwife quoted equates friendship with being an advocate and the second limits the friendship to the period of time of acquaintance. Although both of these may play a part in some friendships, the unreserved interaction which is associated with being a friend is missing in the descriptions. It would seem possible that the relationship is different to a friendship in that the giving is primarily in one direction. One other midwife highlights this:

14: "You can't be completely honest, you can be completely honest with your friends; it's a different relationship... You're there, in a sense, to almost mother them somehow, I can't really say. I mean, from a friend, you would expect care in return I think.... I mean, you don't go and ask what you might ask a friend."

Another way of describing the relationship may be 'friendly' rather than a 'friendship'. One of the midwives interviewed seemed to feel that this is the case:

1: "What's different is that the relationship with your friend is based on whatever but the one with the woman is based solely on one thing and that's her pregnancy. You're professionally involved to care for her and advise her during the pregnancy, labour and postnatally; you're there as a source of information and advice... not the same as a friend but it doesn't mean that you can't do it in a friendly way."

The definition of friendship versus friendliness may be less important than the connection between woman and midwife. The concept of close adult friendship was analysed by Harlene Caroline (1993) who identified certain distinctive features in the relationship. The key issues emerging from this analysis include: friendship is voluntary, it involves significantly large parts of a person's life, and it includes equality of exchange between the individuals. Pairman (2000) uses this analysis to define the 'professional friendship' between woman and midwife, concluding that it fits into the category of a 'borderline case', in Caroline's terms. There is the 'intensity, mutuality and meaningfulness' of a friendship 'but the bond between the woman and the midwife is their shared experience of childbirth' (Pairman 2000:219). Therefore the friendship will normally end once that period is over; there is no endurance of the relationship beyond the childbearing period in most cases.

Walsh (1999) also considers the professional as friend in his study of the relationships which develop within caseload practice. Both he and Pairman suggest that the key features of the 'professional friend' relationship are that it is formed for a particular purpose, with a self limiting time span (the duration of the childbirth encounter) but it encompasses a warmth and interaction which is normally associated with personal friends. Several of the midwives interviewed supported this notion of a fixed period of time in the friendship / relationship and most appeared to feel that friendliness was very important.

There is research evidence that women are looking for midwives who are friendly. Pope et al (1998:147) report from their study that women want a midwife who is "knowledgeable, a good listener, approachable, friendly, pleasant, non-critical and non-judgmental, who has time for the mother and is a good communicator ". Green et al (1998) also found in their research that the attitude of all staff involved in pregnancy and birth made a significant difference to the overall experience. Those who were positive, kept them informed, made them feel special and were on first name terms contributed to the woman's sense of well being. The studies which highlighted the 'warm professional' as an ideal model (McCrea et al 1998), the partnership approach to practice (Fleming 1998a) and the fond memories which women have of supportive, encouraging midwives (Hutton 1994) all corroborate this as an important theme. Simkin (1991) and Wilkins (2000) both identify that mothers remember the midwife who cared for them during the labour and birth for a long time after the event. It is likely that friendliness would make this memory a positive one.

In addition, there is some evidence that midwives also benefit from the mutually fulfilling 'professional friend' relationship. In Sandall's comparative study, she found that midwives with a caseload experienced immense satisfaction and received much support from the women in their caseload (Sandall 1997). Although the opportunity to develop longer term relationships was much more variable in the other patterns of care studied (team midwifery, traditional community midwifery), when it did happen, it was valued by those midwives as well. This has been supported by Stevens' ethnography of caseload midwives where she found that midwives gained substantial benefits from a committed and ongoing 'friendship' with the women in their caseload (Stevens 2002).

The midwives interviewed in this study did not consistently have an opportunity for an ongoing relationship in which to become a 'professional friend'. However they have identified the importance of a close, friendly relationship as an important aspect of their role; this relationship could facilitate the opportunity to make a difference for women.

Continuity

As half of the midwives in this sample worked in a team approach to care, it isn't surprising that the issue of continuity came up in several interviews. However it was not just the team midwives who raised the issue; the core midwives could see some

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definite advantages to the continuity scheme. Some of the positives associated with the approach related to the issue of relationship and of getting to know one another.

Getting to know each other

1: "you get a chance to build up a relationship, you know them before they come in in labour, you know if they've got any problems and you go and see them afterwards; by the time you meet them in labour which is such a critical time for them you know about their life, certain things that are important to them, their ways and it just makes it, you know, much better.. and going to see them afterwards when you've been in their house and you know where they live and obviously for them it's better too, I think"

4: "I think one of the things with the teams is getting to know the women; that's good I think for everybody. It's nice to go into your clinic and you get a lady and you know her, you don't have to go through all the history and you know that if she's got any problems then, hopefully, she would talk to you about them. That's one of the good things, that you know the women."

This issue of getting to know the women and them getting to know you was identified by a number of the midwives as something which could make a difference to the experience.

2: "I felt that because we had this relationship that we got on very well. I did know her antenatally as well and I think that does make a difference. I think if a stranger walks into the room, it takes a while to build up a rapport and when you know you've looked after the woman antenatally, she knows you when she's not in pain and not in labour. She knows you on that sort of basis as well, and I think it helps."

13: "But working in the labour ward, you only deliver them and then they pass on; you don't get to see them again. Not like the group practice (team) where you have seen them throughout; that makes a lot of difference. A lot of times, you seem to know them better by the end."...."The patient has more say in the group practice; in the core, they are always referred back to the hospital for anything and maybe in the hospital clinic they don't have time. (But in the teams) they come up and they need to chat, you can give them some time. You pick up the notes and you see that you know them and if they have a problem, they can phone up and say that they belong to such a team and you can chat to them. But in the core, because there are so many, you don't seem to get to know them."

These comments highlight the value midwives perceive there to be when there is opportunity for the midwife to get to know the woman and vice versa. It appeared to increase their satisfaction and effectiveness as there is no need to constantly start from basics in finding out about women and their situations.

The earliest recorded attempt to introduce team midwifery in Britain was in Scotland in the late 1960's (Auld 1968). Unfortunately that project did not demonstrate more satisfaction for the women; despite this, a number of other services tried to implement continuity schemes soon thereafter. Garcia (1995) identifies those in Machynlleth in 1974, Builth Wells and Newton in 1975 and Llandridod Wells in 1976; all of these were small projects but did integrate community and hospital midwifery services successfully. The first team midwifery scheme to be rigorously evaluated as a randomised controlled trial was the 'Know Your Midwife' (KYM) scheme at St. George's Hospital in Tooting between 1983 and 1985 (Flint & Poulengeris 1989). This trial did show benefits for both the satisfaction of women and their outcomes of labour but the scheme was disbanded at the end of the two year pilot as it was felt too difficult to extend across the service. Wraight et al (1993) reviewed all of the team approaches which had emerged around the U.K., identifying 269 units which claimed they were offering some sort of team approach to care, with the vast majority having been set up after 1987. However it was also found in their report 'Mapping Team Midwifery', that a substantial number of schemes had been abandoned as they were not achieving increased continuity of carer and they were not being supported by both midwifery and obstetric staff consistently.

As discussed in chapter three, these team approaches largely relate to continuity of care rather than continuity of carer. One element which the midwives interviewed in this study valued was the opportunity to 'get to know each other', a feature which may happen but is not inevitable in a team approach. Edwards (2000), in her study described earlier of women planning homebirth in Scotland, found women experienced frustration in a team system. This was as a result of the service being designed so the woman could get to meet each of the six or eight midwives in the team in pregnancy so she had met the midwife on call when she went into labour. Edwards points out that just meeting the midwife, often on only one occasion, did not allow the woman to 'get to know her' and to build up a trusting relationship. It appeared somewhat tokenistic to the women in Edwards' study, better than nothing but not really good enough.

Similarly, women who experience continuity of carer in caseload schemes prefer care from one or a small group of midwives with a coherence in organisation and approach

between them (McCourt & Page 1996). The women in the One-to-One project valued the opportunity to 'get to know' the midwife and her partner as well as appreciating a consistent approach to care. Stevens (2002) reporting on the same scheme, but from the midwives' perspectives, identified clear benefits to the midwife of a continuous relationship. They gained a great deal of satisfaction from being able to really 'get to know' the women and were motivated to give more of themselves as a result. In terms of what the women in Edwards' and Wilkins' studies were seeking, this would appear to be a very positive step.

Green et al's (1998) systematic review of continuity schemes found similar results for the midwives in the West Essex study (Farquhar et al 1996) and the Glasgow Midwifery Development Unit (Turnbull et al 1995), who also felt positive about the opportunity to develop an ongoing relationship with women. Sandall (1997) also found that one of the major themes, which emerged from her interviews with midwives in three types of service (traditional, team and caseload), was the importance of developing meaningful relationships with women. Getting to know women seems important to midwives and getting to know midwives seems important to women.

It's easier

A number of midwives identified that it was easier to support women effectively if they were able to meet women in pregnancy and carry on supporting them through labour and the postnatal period.

4: "Also knowing the woman's medical history, any problems, that makes it easier to be aware of her emotional state because you'd met her and you know what she's like. If she's got any particular worries about the labour, you can help rather than meeting a woman for the first time, you just don't know what they're feeling."

6: "It's easier on the teams because they already know most of the women before they look after them in labour. But on the core, you don't have that chance as you may not have met them before. That's not always the case, very occasionally you will have met the woman before but not usually. That aspect of it I find more difficult, from the core point of view."

9: "In particular, say in labour, when I meet people in labour, I can look after them much better with a better understanding of each other. I know what they're like and how they're going to.. not their pain threshold but how they're going to react, deal with pain, deal with difficult situations, any complications. It's much easier to talk to them

about complications and that's just what I've been finding in the last couple of months. I can just sort of help women much better in labour."

Farmer & Chipperfield (1996:20), two midwives on the One-to-One scheme discussed earlier, claim "it is simply much easier and more satisfying to look after someone you know". Page et al (2000) identify that the opportunity to develop meaningful relationships with women and their families was a key motivating factor for midwives wanting to join this scheme. One midwife I interviewed gave a particular example of how the midwives knowing the woman had contributed to her receiving better support.

11: "I've got an example in that one of the teams had a lady, came in, delivered and the core staff didn't want to let her go home. They felt that she was sort of down or not really sure that she was bonding with her baby. But one of the midwives in the team said that that was the way she had been antenatally, that they knew her and that she should be able to go home and they discharged her... The woman herself had gone to the team and said that they (the core) didn't know her but the team did and she wanted to go home; she knew she was fine and she was."

It was easier for the midwives who had got to know the woman during pregnancy to determine that her behaviour had not changed and there was no risk involved. The midwives on the ward, who had never met the woman before, were unsure as to the significance and therefore did not want to allow the woman to go home. It was easier for the team midwives to contextualise the behaviour displayed and recognise it as normal for that woman.

A core midwife considered that the continuity of relationship probably led to more satisfaction for the midwives, something which has been confirmed in the literature already discussed.

7: "I say that's something about the teams. They have more continuity although sometimes they are not able to cover the team and we end up delivering. I should imagine that, if you have looked after someone like that and been with them, you probably get more job satisfaction."

In addition to communication and a rapport, a further dimension of the woman / midwife relationship may be enhanced through a continuity of care arrangement. Those team midwives interviewed valued the opportunity to have an ongoing relationship so they were able get to know the woman better and be able to determine

her needs and wants more effectively. They appeared to get a great deal of satisfaction from this type of practice and those on the core also saw the benefits to women and midwives. This relates back to the issues raised about continuity in the literature in which there are positive gains identified for practitioners and clients (McCourt & Page 1996, Walsh 1999, Walker 1999). It is not an essential aspect of practice but is one which seems to enhance the ability of the midwife to make a difference for the woman.

It Was Special

Whether or not continuity was a feature of the care system, midwives highlighted how nice it was to be able to make a difference for the women. Several described 'special' relationships or experiences that had proved satisfying.

1: "Because you can make a difference and it's satisfying. It's nice to know that you have the power; perhaps power isn't the right word, to meet somebody and to help them achieve what they want, whatever it is. If they want to have a normal delivery, they want to have a home birth or they want to have a section. Whatever, it's nice to feel that you can do something if you meet somebody who has met people before and had a problem and nothing was done about it. To be able to step in and act on it and do something and change things for that woman is very satisfying."

This midwife appeared to feel good about being able to facilitate the type of care that the woman wanted to be able to advocate for her especially if the woman's past experience had been negative. She seemed keen to be able to make the event special for the woman; if she could achieve the desired outcome, she felt satisfied. Another midwife described a situation where she had given the woman the confidence to ask any questions she wanted, no matter how trivial, without the woman feeling inadequate. This had led to the relationship feeling special to this midwife and, presumably, to the woman as well.

4: "Maybe whether it was the first time she came into contact with a midwife- we seemed to get on from the first time we met and it gradually sort of grew. She knew that she could always come to me, she said 'thank you for putting up with my fancies during pregnancy'. Every time she came she had a question and sometimes they were a bit silly. But she knew they were and she knew she could ask me. We just sort of seemed to get on and we still keep in touch now."

One of the midwives interviewed worked exclusively in the antenatal clinic therefore her sphere of contact with women was more limited than for some of the others interviewed. She still described some of the relationships as special, focussing on the women who needed support through the challenging process of antenatal screening tests.

5: "I get involved with women over the issue of screening. If they choose to have serum screening and then need an amnio, I tend to give them my contact number and they tend to ring me if they have any questions or if they want to talk. So I build up a special relationship from that end."

These remarks describe situations in which the woman looks to the midwife for something specific, where the woman has a need which the midwife can help to fill. Being able to help meet that need was described as leading to a 'special' relationship.

The issue of 'specialness' in the midwife / woman relationship is one referred to by a number of writers in midwifery (for example, Flint 1987, Page 1988, Cronk & Flint 1989, Wilkins 2000). However, the factors which contribute to this quality of relationship may be diverse. The three midwives quoted above seem to indicate satisfaction derived from being needed; in the situations described, the midwives enabled the women using professional action, knowledge and skill. Their interventions contributed to positive outcomes for the woman (as the midwives saw it); the payback was that the midwife felt good about being able to do so. There is a fine balance of power in these situations; the first midwife verbally tripped over her choice of that word. Despite correcting herself on its use, she did seem to indicate that it was her who made the difference rather than empowering the woman to take control and achieve her desired outcome with the midwife in the background. This concept of 'doing things' is explored in Nicky Leap's discussion 'the less we do, the more we give' (Leap 2000) in which she identifies the disempowerment women can experience when the midwife feels the need to be 'doing'. Her reflective account of her practice as a midwife identifies the positive impact of minimal disturbance, direction, authority and intervention can have on more than just the physical outcome for women. Quiet, calm, non interventionist midwifery support can lead to women feeling that they themselves have achieved the positive outcome without the sense of dependence which is described by the midwife in the second quotation above.

Similarly, Cronk (2000) uses transactional analysis terms to define the ideal midwife / mother relationship as one which is adult-to-adult, as opposed to parent-to-child which is often the case in professional / lay relationships. Wilkins (2000) supports this approach with her recognition of the limitations of the professional paradigm in midwifery which creates a power differential in the relationship (as discussed in chapter two). In her research, she found that women defined the relationship with the midwife as 'special' when it was personal, when the midwife and woman got to know each other as people and not just professional and client.

A number of the midwives interviewed described situations which appeared very personal, involving close contact, touch and real connection. In these situations, described below, the midwife seemed to be acting out of the professional paradigm in the support offered to labouring women. In these situations, the midwives appeared willing and able to make a special effort to support the women.

Special Effort

The descriptions of birth situations which the midwives defined as special, related to times when they appeared to have made a special effort. The 'specialness' appeared to come from the acts of the midwife being valued by the woman; this led to satisfaction for the midwife who felt that she had contributed to making a difference.

4: "One was with a friend, she was a midwife here... It felt good to be part of her labour and to be at the birth. It felt good to be the midwife with her in labour. I'd been with her at home and then coming in with her; that felt that she sort of valued my experience and friendship and being trusted as well. It's quite a sort of important event to be with someone and to be chosen..."

7: "They have put their arms around my neck and on my head and chest and I've rocked with them and then they go on to have a lovely normal delivery, no analgesia, that's been lovely and really all I was doing was supporting her through the birth."

2: "The woman's husband had a bad back and he spent most of the labour either lying on the bed on or on the floor. But we just danced... we had dancing music and rocking music so we danced for a certain length of time to a kind of poppy music- Oasis or Alanis Morisette- and then she got into the rocking chair and just rocked and we turned the music right down and put on some really quiet music and she shut her eyes and put her head back and breathed, totally breathed through. And then she got up again

and we started dancing right up until the head was almost on the perineum. It was great. It really was."

10: "I was very excited and she was excited because it was her first birth and to me it was my first water birth, if we got there. Very early on, even on the phone, I'd been talking and liaising with her but I'd never seen her. Over the actual day, I'd spoken to her twice on the phone, actually it wasn't her I spoke to, it was her husband who was very friendly. So when she came in, it felt as if we had already met although we hadn't. So I looked after her from about 8.00 and I called in my manager, Jane, to be the second midwife. Communication between us was lovely, I was able to give them the space they needed, cause they were in the pool and to allow them to do whatever they wanted as in bringing in candles.. anything to make the environment their own. Me and her, we did hit it off; it was lovely especially at the end, when there was problems and we felt comfortable with each other."

11: "It was my first time out in the community and it was really good. I had my first experience at a home birth; I'd never been at.. well I'd seen a home birth as a student midwife. But I took on a primigravida who wanted a home birth so I met the lady and what I used to do was when I'd finished my shift, I used to go in the evening to see her at home. We built up an excellent, I think we built up a, very good rapport and I saw her all the way through. When she went into labour, she called me. She used aromatherapy oils and was in the bath and it was lovely. For a first time Mum, I thought she was really, really good. I'd say that that was probably my best delivery."

12: "I remember looking after a teenage girl with her Mum and a young boyfriend was there. In that room, we felt such a close community that I didn't call a second midwife for the birth because that would have been an intrusion; there were enough people in the room. We didn't really need a second midwife for the birth. That was a really nice birth."

These descriptions suggest that the midwife may be able, on occasion, to really make a difference. The midwives appeared excited when telling me these stories; they remembered these particular births with very positive feelings. The concept of reciprocity (Campbell 1984) within the client / professional relationship appears pertinent here. These midwives gained from the experiences with these women as the women gained in return. Fleming (1998b) found the issue of reciprocity to be a core theme in her research with midwives and women in New Zealand and Scotland. The interconnectedness between woman and midwife was defined as embracing the whole relationship, in her study. Stevens (2002) also found that midwives in caseload practice appeared to gain substantial satisfaction from the close relationship with women and, as a result, were more willing to make themselves available and responsive to women's needs than those in the conventional maternity service.

This interconnectedness suggests that the benefit gained from a close relationship and positive experience is two way. The woman needs the midwife to provide her with the support through labour and benefits from the midwife making a special effort to meet her needs. However the midwife also needs the woman; some of the words in the quotations above identify the satisfaction derived from being considered as significant to the woman's experience. Comments like "it felt good to be part of her labour", she "valued my experience", and it was special "to be chosen" all support the concept of reciprocity. The description of dancing through the labour, the excitement associated with attending one's first homebirth and the avoidance of involving anyone else in the birth to prevent intrusion provide evidence that midwives benefit from positive outcomes for women as a means to job satisfaction.

The midwives interviewed clearly derived great satisfaction from providing effective support to women and valued special relationships, probably reaping as many benefits from these as the women. However, the potential of the energy which is created in these special relationships, this partnership between midwife and woman, seems largely unnoticed and unexploited by these midwives. In the model of midwifery practice adopted in New Zealand (Guilliland & Pairman 1995), the partnership between women and midwives is the foundation. The strength of this partnership approach was sufficient to challenge the previous approach to midwifery practice which was reminiscent of the British NHS with midwifery status aligned to that of nurses. In the new partnership approach, midwives are seen as equivalent to doctors, in an organisational sense, and have a legitimate role in the health service without being or feeling subordinate to medical practitioners. This scenario is very different from the one described in chapters two and three of the midwifery context in the U.K. In New Zealand, it was in partnership with women that the status quo was challenged; the strength of both sides of the partnership provided a powerful force for change. The power of partnership was not discussed by the midwives interviewed but their enthusiasm and excitement in describing these special experiences intimates there is an unexplored potential to be considered.

'Specialness' is remembered by women, as is confirmed in the quotation in chapter three "I think that in a perfect world every woman should have what I had - a midwife's

face that said 'look we have performed a miracle together!'" (cited in Oakley 1989:220). These midwives easily remembered some of their most positive experiences and shared their stories willingly. It may be as important for the midwife to experience special events as it is for the woman, to gain satisfaction from their roles and to be willing to make a special effort to meet the woman's needs.

Preparing

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┌─────────────┐          ┌─────────────┐          ┌─────────────┐
│ Advice      │ ───────▶ │ Knowing what to │ ──▶  │ Preparing   │
│ Teaching    │          │ expect      │          │             │
└─────────────┘          └─────────────┘          └─────────────┘
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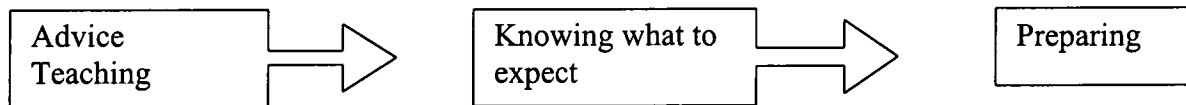
It is not surprising that the word 'preparing' appeared frequently in the data, as one of the activities of a midwife defined by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting is just that:

> To provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition
>
> The Midwife's Code of Practice, UKCC 1998

This important theme, although a very significant part of the midwife's role, appears less frequently in the data than the other two. On reflection, it appears that the midwives took for granted this part of their role and, although they used the word 'preparing' quite frequently, it was relatively unexplored in the interviews. However, there is sufficient reference to it for this to be considered an important aspect of midwives' work. All of the midwives interviewed talked about teaching women, giving them information to help them to make choices and to be prepared for the birth and motherhood. The midwives interviewed included the aspects of preparing women for the birth experience and for motherhood as a key aspect of their role. This important, but not extensive theme, included one key category within it which relates to providing advice, teaching and helping women to 'know what to expect'.

Knowing What to Expect

The midwives interviewed identified two ways in which they helped women to know what to expect. They gave them advice and they gave them information or taught them.

Advice

The midwives used the word 'advice' in a number of cases, to define what they offer women in preparation.

1: "You're professionally involved to care for her and advise her during her pregnancy, labour and postnatally; you're there as a source of information and advice that will be good for her..."

2: "help, support and advice..."

4: "We're there for help, support and advice..."

7: "Advice on diet etc. antenatally, dealing with labour and then postnatally...you offer advice and support."

14: "The midwife is there beside her to support her. They usually have their partners there, they go into it together. They get advice from the midwife."

This fairly superficial use of the word 'advice' made it seem like part of routine patter, a concept which these midwives had not really considered. However, the word 'advice' has been criticised as being laden with individual judgement. Enkin et al (1995) comment that:

> A pregnant woman is subject to a variety of prescriptions and proscriptions to modify her customary or desired life-style, in the guise of 'advice'. Unlike ordinary advice, however, there is frequently no option of refusal. Those believed-to-be authorities on reproduction, such as physicians, midwives and childbirth educators, can give advice that appeals powerfully to the pregnant woman's desire for a perfect pregnancy and a perfect child. The effectiveness of this advice must be questioned and evaluated as rigorously as every other intervention carried out during pregnancy.

This quotation indicates that there is an ethical dimension to the concept; those in control of the situation can proffer advice to the powerless with the expectation that they will follow it (as in the professional / lay relationship). Certainly the first midwife interviewed intimated that she knew best about what was good for women. The superficial use of the word could indicate that the midwives quoted had not really

considered the effect that giving advice could have on women. One midwife struggled with the difference between advice and opinion:

10: "If women ask my opinion, I tend to give them all the information and say that I don't usually give advice but if they want my opinion, I'll share it. Especially in terms of screening tests. I'll tell them what I think but let them know that I'm influenced by my cultural background."

Despite her attempt to avoid advising women, this midwife's opinion, especially in this emotive area of practice, could have been just as powerful in swaying the woman's actions. It may be somewhat unhelpful to the woman to have to interpret the impact of the midwife's background as part of evaluating the significance of her opinion, as well. Another midwife described a positive way of providing advice, one in which the woman was given practical information which she could use to make decisions:

9: "I'll always tell a woman why I'm asking something. If I'm worried about a woman, her blood pressure let's say, but it's not high enough to bring her in, then I'll tell her what to look for and I'll write in my notes 'advice given about swelling overnight, dizziness, headaches, blurred vision' and tell her to get in touch with me or come into hospital."

It is not clear whether the midwife explained the significance of the symptoms in relation to high blood pressure, however. Following this interview, I asked the next three midwives whether they felt that they should share with women the significance of pre-eclampsia to the woman and her baby. One of them indicated that this might be too frightening:

12: "I suppose you don't like to tell a woman that she's likely to have a fit!"

Another suggested that it was the midwife's responsibility in the end:

10: "Well it is very difficult cause you feel that you do have to keep an eye on them. There comes a time when you just have to say 'I'm in charge and I know what I'm doing."

The third did not really answer the question but embarked on a tangential discussion.

The reluctance to share the harsh realities of pregnancy relates to the notion of 'protective steering' as described by Levy (1999). In her study of the ways in which midwives facilitate informed choices during pregnancy, Levy found that midwives, at times, suppressed information to protect the woman. The midwives involved in her research provided information to assist women in making choices but the information was limited in order to steer the woman in the direction of, what the midwife perceived to be, the safe choice.

This approach has its roots in paternalism which has historically been the norm in medical practice (Harding 2000). The paternalistic physician sees his / her role and responsibility as that of making decisions for the patient based on knowledge and expertise, then guiding the patient to an understanding of why the decisions have been made (McKinstry 1992). Emanuel & Emanuel (1992) describe the paternalistic model:

> In this model, the physician-patient interaction ensures that patients receive interventions that best promote their health and well-being. To this end, physicians use their skill to determine the patient's medical condition and his or her stage in the disease process and to identify the medical tests and treatments most likely to restore the patient's health or ameliorate pain. Then the physician presents the patient with selected information that will encourage the patient to consent to the intervention the physician considers best. At the extreme, the physician authoritatively informs the patient when the intervention will be initiated.

> Emanuel & Emanuel 1992:2221

Kaplan et al (2002) point out that the paternalistic model is based on an assumption that there are objective criteria for determining what is best for the patient, making it possible for the clinician to make a decision with very limited patient participation. Harding (2000:73) suggests that there is a common belief that "physicians will only make decisions based on scientific knowledge, medical expertise and their professional commitment to act in the patient's best interests". This presents the image of the physician as the rational expert with a mission to solve the patient's problems for them as opposed to with them, a similar image to that created by the quotation from midwife 10. It also relates back to the previous discussions on the effects of professionalisation, science and medicine and the gender issues in hierarchies. The power differential within the maternity service sits the obstetrician / doctor at the top, with midwives in lesser positions and women at the bottom of the pile. The approach of

providing advice as a means to educating women would seem to perpetuate these power relationships.

There was little confirmation in the interviews that advice was used to empower women. It appeared as another thing in the list of things which midwives do and it may be that these midwives had not considered the potential negative impact 'advice' can have, working on the paternalistic assumption that they, in fact, do know best. This is in a context in which midwives have relatively little authority in the system as a whole but as 'street level bureaucrats' (see chapter two) are able to exert considerable influence over women's choices. The potential of this influence appeared to be largely unrecognised in the group of midwives I interviewed.

Teaching

The midwives indicated a number of different areas of preparation which are helpful to women including the changes and care in pregnancy:

5: "We give out lots of information about what is going to happen to you during the different stages of pregnancy. Information about blood tests, screening and other tests that are on offer, and the things we do to see that things are alright, the antenatal checks."

4: "maybe you do sort of build a plan of, to some extent, what's going to happen, tell them when they're going to be coming back to the hospital, what's going to happen at each step, not week-by-week but month-by-month..."

in anticipation of labour:

5: "what to expect in labour..."

9: "giving information and talking about labour and showing them what they're going to face when they come through those doors."

and parenting or the changes which will happen following the birth:

1: "preparing the woman and her family for how to cope with the changes in her life"

3: "Your needs are likely to be for information, support, actual physical care like blood pressure measurement and urinalysis or palpation, talking about things like breastfeeding, how to cope after having the baby, who's going to help you at home, what the immediate postnatal period involves, what kind of help you'll have for it."

4: "We do parentcraft that involves teaching about getting ready for the baby, labour, pain relief, taking the baby home, breastfeeding and all that really. Preparing them- I guess it's sort of education really."

11: "The clientele or the ladies that we have here are from such different backgrounds so some of them may need parenting skills or some of them may need to know where they go about to sort out social, housing problems or just for support."

There appeared to be no doubt that helping women to know what to expect of labour and birth was a part of what these midwives do; setting realistic expectations of the experience would seem to be a vital part of this preparation. Green et al (1990) found in their large, rigorous study of women's expectations of birth, that expectations were directly linked to outcomes (that is, women who expected labour to be very painful were more likely to be able to cope with it without using pain relief, and that high expectations of the birth experience were associated with improved outcomes). Women tell us that they are keen to have the full story of labour 'warts and all' in pregnancy so that they know what to expect in labour (Nolan & Hicks 1997). This finding is supported in Anderson's grounded theory study of sixteen women's experiences of the second stage of labour (Anderson 2000). She found that women felt betrayed if they were given inaccurate information about progress or possible outcomes during labour. Even if the midwife told 'white lies' in order to encourage or protect, the women felt let down. "None of the women appreciated being kept in the dark or being given inaccurate information or false hope" (Anderson 2000:110). They also wanted to know about it 'warts and all'.

The desire to understand the realities of labour and birth would not be supported by Levy's (1999) 'protective steering', as described earlier. Midwives wanting to protect women from reality and, in so doing, refraining from honesty may be an unhelpful approach, although probably one adopted with the best of intentions. This relates back to the paternalism raised in the previous section; midwives doing what they feel is 'best' for women rather than involving the woman in the decision.

One of the midwives interviewed described a situation where she had prepared the woman antenatally but the woman's expectations had not been fulfilled during the labour and birth:

1: "I can remember one who was a physiotherapist who was, you know, very motivated and keen and wanted to come in in established labour and have a relatively drug-free labour with maybe just Entonox when she had her baby. And she had a complete and absolute night mare... epidural, forceps delivery, PPH, blah-blah-blah, it was a disaster as far as she was concerned. She had a healthy baby and she herself was going to be fine but that wasn't the way she saw it. Even though I had nothing to do with her birth it was just knowing her and knowing what it was she wanted, I didn't even want to go in and see her... I think some of these women have such a big problem afterwards."

Clearly this woman did not achieve her expectations. This begs two questions - were her expectations realistic? and was her preparation appropriate? This midwife went on to say that she feels guilty when there is a mismatch between the woman's expectations and her experience:

1: "I don't know why you should feel guilty but I usually do, I can't explain it, even if you weren't involved, you feel that maybe there's some way in which they should be prepared more, that they weren't prepared at all for a difficult birth, even though you've done your best in antenatal classes."

Although women do learn about birth in antenatal classes and from health professionals, it is recognised that this is not the main source of their information. The media, in the form of television, radio, newspapers, magazines, books and advertisements make the largest contribution to women's images and understanding of birth (O'Connor 1993, Jacoby 1988). It is also recognised that the media portrayal of birth may be somewhat unrealistic. "Typically the baby is in jeopardy, and the Mom is either actually dying or wishing she were dead. Those who make it (whew, that was close!) are saved by valiant medical efforts, clever technology, emergency procedures or sheer luck" (Edmunds 1998:12). Alternatively, births are often quick and easy on television with barely a bead of sweat appearing on the labouring woman's brow.

This indicates the need for a balance in the preparation which midwives provide for women, to counteract the effects of media which tend to be at one extreme or another. But it would seem that midwives are not always able or willing to share a realistic view with women. They tend to modify the woman's expectations as they are unable to

ensure the type of birth the woman wants is achievable in a large bureaucratic organisation. As a 'street-level bureaucrat' (see chapter two), the midwife is in between the needs of the client and the needs of the organisation. Managing the tension in this scenario means that midwives need coping strategies; modifying women's expectations may be one means by which the midwife is able to cope with this stress.

There may also be an attempt, through the use of birth plans, to help women to think about their expectations of labour and birth. This tool enables women to articulate their wants in advance of labour and birth and can be used as a communication tool between woman and midwife. However four of the midwives interviewed identified that these plans in themselves were unrealistic.

13: "See a lot of times, we encourage the Mum to do a birth plan and then we talk about it and see where we can go. A lot of times you see that they write something down, that they don't want an epidural, they don't want this and then a lot of times they can't cope with the pain and they ask for injections and they ask for an epidural and then they think that they are a failure because they're not doing what their body should do."

10: "We'll go through your birth plan but you are aware that things might change along the way and you have to change your birth plan as we go. You just can't stick to what you've written."

9: "If I'd met her antenatally and knew about her birth plan, then I would have nipped it in the bud and said 'Look Margaret, what happens if you go over your dates, what happens if this happens?"

11: "Explain to her that there's nothing wrong with that (having a birth plan) but that there are occasions when things deviate from that and it's nothing to do with her failure, it's to do with the pregnancy and to learn to accept it..."

These comments highlight two important issues; women can end up feeling like failures if they do not achieve the birth of their dreams and midwives do not always appear to be proactive in helping to set realistic expectations. Despite the rhetoric that midwives should be helping to set realistic expectations, the reality for some of the midwives interviewed appeared to be more the case of limiting the expectation of normal birth. In all of these cases, the midwife believed that the women were possibly setting themselves up for disappointment. Their reaction to this appears to be to identify to the woman that things may not go according to the plan and that they should

anticipate the worst. Relating to the work discussed earlier by Green et al (1990), this negativity may have an impact on the woman's experience by limiting her expectations unnecessarily, introducing the idea that her body may not be able to achieve birth without intervention. However, as street-level bureaucrats, these midwives tended to use the birth plan as a tool for redressing expectations rather than one by which the midwife could help to create the environment the woman sought.

One midwife clearly stated that the expectation of spontaneous birth is an unnecessary priority:

12: "It's such a shame really that women have almost a competitive approach to childbirth that they feel they've failed unless they push the baby out themselves. I'm always going around saying to women 'It's not a competition having a baby. You'll get a baby. You'll have a child. Whether it comes out by forceps or Ventouse, naturally or Caesarean, it's not a competition that you have to win'."

This midwife went on to say:

12: "People should think that they're lucky if they can push the baby out rather than feel a failure if they don't."

Comparing these comments to the earlier ones, where the birth was considered special and exciting to the midwives, there seems to be a mismatch. These midwives derived great satisfaction from births which required no intervention yet they suggested that it was the sensible thing to mediate expectations as intervention is often necessary. It raises the question as to why they feel unable to help women meet their expectations and why women should feel 'lucky' if they are able to birth unassisted; this will be explored further in the next theme of 'making sure'.

Making Sure
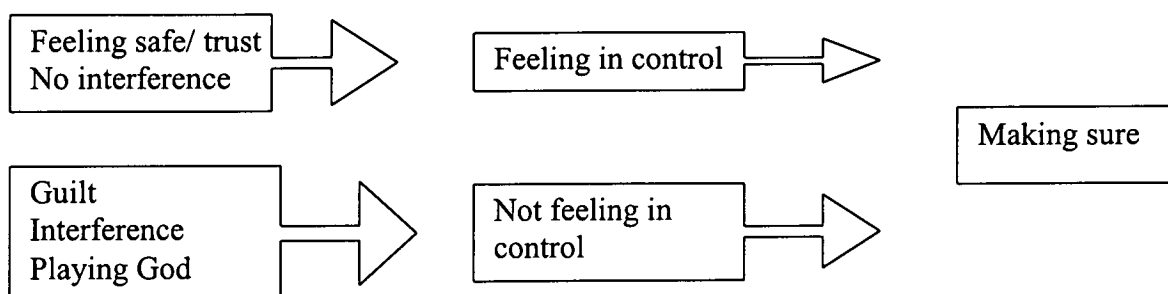
The words 'making sure' were used by many of the initial midwives interviewed. They said that their role was to 'make sure' that all was well, that the baby was growing normally and that everything was progressing normally.

1: *"You review their history, the medical history, the family history and you're searching for, you know, you want to make sure that all is well as it were and you make a plan for the woman's care in the pregnancy and.. umm.. explain to her how you are going to check that everything is well with her and the baby and that everything's progressing normally....providing the type of care, assessments, examinations to make sure that everything is progressing perfectly normally in the pregnancy and then monitoring for deviations from normal... "*

2: *"Making sure that the baby was growing properly, that she was well during pregnancy."*

3: *"Making sure you have an understanding of the system and situation, making sure that you know what the role of the GP is, making sure you know where you can go to have the baby, the hospitals in the area or whether you wanted to have the baby at home..."*

4: *"We're there to make sure there are no problems in the pregnancy and to refer when necessary....checking her blood pressure, checking her urine and making sure that the baby's growing by palpating, listening to the baby's heart beat for fetal wellbeing"*

6: *"Our main aim is to ensure the safety of the mother and baby at all times."*

8: *"So screening, educating, planning together for an optimal childbirth of convenience to make sure that both mother and baby- well, to make sure the mother has a healthy outcome and the baby does too."*

These quotations all intimate that it is within the control of the midwife to ensure a positive outcome for mother and baby. It sets a somewhat idealistic / unrealistic picture of midwifery practice; somehow the interaction with the midwife in pregnancy will prevent complication. It suggests a level of power which would appear to be unlikely; therefore this substantial theme relates to the power or powerlessness of these midwives in their practice. The categories within the theme relate to when midwives feel in control (feeling safe and no interference) and to when they do not feel in control

(interference, guilt / feeling you've let her down). There is a key category relating the control of both midwives and women (playing God).

Feeling in Control

Several of the midwives described times when they appeared to feel in control of the situation, possibly their perceptions were that they were able to make sure that everything was alright. These descriptions were positive; the midwives talked about them with warmth and caring attitudes.

Feeling Safe

There was discussion about how important it was for the woman to trust the midwife who was caring for her; the midwife needed to make sure the woman felt safe in her / his hands.

5: "Making her feel safe...I felt they were special because they trusted me and I felt I did give them support. When I gave them the results, I just felt that I could give them the support they needed and felt that they felt it as well."

6: "I felt she trusted us. Sometimes, no matter how long you are with a woman, you don't get that. You have not been in the room long enough or you get called elsewhere or the woman just doesn't get involved. The outcome was that she felt good about it. She never felt she could do it and the fact that she did do it, could have changed her for the rest of her life."

7: "They learn to trust you really, they build up a rapport when you are looking after them and they trust you..."

9: "Well yes it is, because if a woman is frightened in her labour, especially if it's her first baby, they're frightened of the abnormal. And I do feel that being with them, you do sort of reduce that when you're with them all the time. You know the woman and you're there for twelve hours. It's a long time really, isn't it, twelve hours? It's better than seven and a half because you get to spend longer with them and hope that they will deliver with you. Just the last few cases, I've started to follow women through and I think that they feel safe."

10: "She ended up being delivered by someone else, but it actually came back that I looked after her postnatally and the trust was still there, we were still close. It has even been fed back to us following, that the team has been very good, myself and one of the other girls who were there for her all of the time, supporting her. She said that she knew that the midwife was there for her and supported her all the way through."

13: "Put it this way, since I've gone into the group practice, I've put a lot of hours to those ladies. My shift is supposed to start at 8.30 and finish at 4.30 and lots of times, I stay on because you get to know the clients and, like you said, they put trust in you. They want you to be there and you can't just turn away. I have a lot of good memories on that and the outcome is great. You got to know them and they got great trust in you."

14: "It's just because of my experience, I can say to the woman that I've done this so many times and they do trust me."

A number of issues are raised in these comments; it can help a woman to feel safe if there is time to get to know the midwife (as discussed earlier), if the midwife's experience and knowledge is obvious and if helpful explanation of what is happening and why is provided. This appears to be an integration of the 'art and science' of midwifery; the knowledge base being used effectively through supportive communication and contact to secure a feeling of safety. In these cases, the midwife appeared to commit to the woman and the reward was a trusting relationship in which the woman had faith in the midwife.

The midwives interviewed in this study corroborated the importance of trust in the midwife / mother relationship as has been identified in many other studies. In fact, trust appears to be virtually uncontested as a key feature to positive relationships between women and midwives; some recent studies highlighting trust as a valued issue are provided as examples.

Harding (2000) found in her small exploratory study about shared decision-making in midwifery that most of the midwives interviewed felt that the relationship with their clients was based on trust and that trust was as crucial for the midwife as it was for the women. Trust was also an important issue in Edwards' study of women planning homebirths in Scotland (Edwards 2000) where the opportunity to get to know the midwife helped the women to feel that they could trust her / him to do the best for the woman, rather than just hoping that the midwife would act in their best interests. Similarly, Anderson (2000b), in the study referred to earlier about women's experiences of the second stage of labour, identified that women needed to feel able to trust the midwife in order to be 'safe enough to let go' and birth the baby. Kirkham (2000:242), following her extensive research experience in the field, suggests that

"feeling safe enables us to achieve our maximum potential, either as mothers or as midwives".

This trust seems a key element of the partnership between midwives and women, described on page 176. However, unlike in Harding's study highlighted above, the trust described in these interviews was one way. They focused on the need for the woman to trust the midwife and there was no reference to the need for the midwife to trust the woman. In reflecting on the previous discussion about 'preparing', it would seem that these midwives did not always feel able to trust women or at least their ability to birth without intervention. As illustrated in earlier quotations, they felt that women had unrealistic expectations, they set themselves up for failure and they were often not able to achieve their preferred outcomes. The midwives addressed this by modifying expectations rather than by making every effort to support the woman's hopes; this would not seem in keeping with a mutually trusting approach.

As discussed earlier, these midwives did not seem to really believe that women can achieve their dreams. Despite pointing out the importance of the woman trusting the midwife in these interviews, these midwives did not demonstrate a trust in women. They did not really seem to believe that women can achieve their goals. Perhaps the positive experiences, where women birth in uninterrupted and supportive conditions, were too few in their practices to really generate that belief. The cases where intervention and interference took place may have been so prevalent in their experiences that they overshadowed the more positive ones. The importance of socialisation as a learning process was discussed in chapter four; these midwives would be the products of their socialisation into midwifery. With medicalised birth and virtually routine intervention an increasingly common phenomenon, the opportunity to develop a belief in women and nature, to be able to trust them and their bodies, may have escaped these midwives to any significant degree.

This 'not allowing themselves to believe that positive births should be the norm' may also be a protective mechanism in order to prevent disappointment for both the woman and midwife. As discussed earlier and in chapter two, although midwives are in relatively powerful positions in respect to individual women, they are not particularly powerful in the large bureaucratic organisation of the health service. The medicalised

approach to birth, with virtually routine intervention, is a norm which midwives have been socialised into accepting in many cases. If a midwife decides to step outside the norm of practice in a maternity unit for the benefit of a woman, there may be a backlash in the form of the horizontal violence, also described in chapter two. Stapleton et al (1998) identify that midwives experience a significant pressure to conform in the health service, as well as a lack of regular peer support offered to colleagues. In their study, they found that midwives "do good by stealth" (Stapleton et al 1998:145), not wanting to expose their good efforts in case they are scapegoated or blamed. Ultimately this leads to a learned helplessness culture; midwives feel it is impossible to change things and so lower their expectations to avoid disappointment. This is reflective of Lipsky's (1980) analysis in which workers alter their own expectations to survive in the bureaucracy, as well as those of the client. It is also supported by the way in which students in the studies presented in chapter four 'learned to behave'. There would seem to be a cycle of negativity being perpetuated in contemporary midwifery in the traditional maternity services, one in which it is difficult to believe.

However, trust between mother and midwife seems important; the rapport established between the two parties will clearly have an important role to play in establishing this trust which, when things go well, can provide enormous satisfaction to midwives. But the midwives interviewed focused only on the importance of the woman trusting the midwife, not referring to their trust of women. Women's trust is not an inevitability in the relationship. The descriptions above indicate a closeness between the midwife and woman, one where it is not interrupted by other members of the multiprofessional team, one where the midwife appeared to feel in control. This lack of interference, leading to the midwife feeling in control, may be key in the establishment of a positive relationship with women from the midwife's perspective.

No Interference

Many of the 'special' experiences which the midwives described (quoted earlier) were cases in which the labour and birth had progressed normally. One distinctive feature of these special births was that there was no need for any interference by any other member of the team. The perception could be that the midwife was effective in making

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sure that all went well. The desirability of this situation was confirmed by a number of midwives.

1: "She had a normal delivery and it was very nice; we didn't have to involve anybody else. But for that woman it was very easy; it's just the way it happened for that woman."

2: "The main reason why I felt it was special was that I didn't have the woman chained to the monitor, I didn't have the obstetrician in and out of the room every two minutes; I felt that I did... I made all the decisions and did everything as I thought was appropriate and had nobody else come into the room and making comments and assumptions. It was actually in this room, the lady was- it was quite a big baby actually- she was an induction but she just progressed in labour fairly smoothly and we had music, dancing, dimmed lights and hardly any CTG tracing at all, only when I felt it was necessary. She had a ten pound baby, it was her first baby with an intact perineum, everything was straight forward and it was lovely."

3: "The lady progressed very nicely through labour, nobody came into the room while she was delivering, we just got on quietly together...That was lovely, it was just quiet, straight forward, she seemed very happy with everything and it just all went very well."

5: "Because nobody was interfering. Because it was really what the person was doing, it really was a normal delivery. She delivered the baby, the woman did. We only actually deliver babies when women have sections. Normally, they deliver their babies. We just help."

7: "I feel I'm doing more for the woman when it's not medicalised. Everything is normal and you don't need the GP. You don't need the doctors. That's the one thing that used to get me down at my previous place; it was very medicalised. The doctors would come in and introduce themselves and you felt like saying 'Everything's fine, you get out of here'."

10: "If it's normal, we can stand up on the highest soap box and just say 'Get away!' but if its abnormal, then it's the doctor's case and it's very hard for us to get away from it. As far as the relationship with the woman goes, it seems that we're more for the doctors than for them in those cases."

There seemed to be a great deal of satisfaction derived from being able to support the woman without the need for any other staff to become involved. All of these comments suggest that success equates with no interference and the last two indicate that the midwives would rather not hand over care to medical practitioners. The midwives interviewed appear to hold onto the ideal of a birth that is 'normal' but the specialness

of the experience seems to indicate that these ideal births are not the usual (or particularly common) experiences.

When complication arises, the involvement of a doctor splits the midwife's loyalty; she / he may no longer be the unique source of support for the woman and she / he also has a role to play in supporting the doctor in providing appropriate care. This can lead to frustration especially if there is a mismatch between what the doctor says to do and what the midwife feels is appropriate; that frustration was displayed by these last two midwives quoted, in a confrontational way. The midwives quoted appeared to resent the intrusion by the doctors and would make every effort to be sure that they were not involved unless absolutely necessary. The relatively disempowered position of midwives in the hospital / medical hierarchy, as discussed previously and in chapter two, may play a significant part in the way midwives react to the need to refer to medical colleagues. They would rather stay in control of the situation and therefore resent having to include doctors who are likely to take over the decision making and plan of care.

Not Feeling in Control

For as many times as the midwives interviewed gave positive examples from practice, when they felt in control and able to make sure that the experience went well, there were negative ones, where this had not been the case. There was frustration, guilt and the feeling that the midwife was letting the woman down in many of the stories they told me. The ability to actually be able to 'make sure' all went well does not appear to be borne out in practice as, many times, they needed to involve another health professional and, often when this was the case, things no longer felt positive.

Interference

In cases where complication arose, a doctor or a more senior midwife became involved in the care. Things changed in these situations; the closeness of the relationship was interrupted, the midwives appeared to try to salvage the relationship by being the link between the doctor and the woman. There was a feeling of disappointment and dissatisfaction described in these situations.

9: "I had a lady here who had twins, it was her second pregnancy, she had a little boy. Everything was grand in her pregnancy, everything was normal and then in labour she got to 10 centimetres, she was about to deliver her baby and this doctor, this registrar comes in, and said to me 'Right what's happening- how is the second baby coming? Do this.. do that...' and when I was delivering the first twin he says 'Right. Let's do an epis.' for the first twin like and I looked at him and I said 'no' but he took over straight away instead of looking at what was happening and he said 'Do an epis'. I said 'no, she's had a baby before and it's a small baby. I've felt and there's plenty of room. She doesn't need an epis.' He said 'but what about the second twin? We always do epis for twins.' I thought but what about if the second twin doesn't come straight away, look at all the bleeding she's going to have. He kept at me to do it and near the end because the paed was looking at me and the parents were looking at me, I said 'yeah, yeah, o.k.' and didn't do it but I got everything ready and then a G grade sister comes in and I asked her if I should do an epis for twins and she said 'yeah, yeah, yeah' but she didn't listen to me she was busy getting things ready. So because I'm new here and she said yes I thought well I'd better do it then, so I did it and the next twin didn't come til about 25 minutes later and the woman just bled and bled the whole time. She didn't need the epis, I know she didn't but he came in and ordered me to do it and the whole situation with the parents looking at me, it put a strain on them, there had been a relaxed atmosphere, everything was happening normally and he just put a whole different thing..."

This situation was clearly stressful for this midwife. The doctor had ordered something which the midwife felt was not the best suggestion in the situation. She felt disempowered as she was new to the maternity unit and was being watched by the parents and paediatrician as well as the obstetrician. She looked to a more senior midwife for support which was not forthcoming so she followed the orders, knowing that the outcome was likely to be negative for the woman. Another midwife described a situation in which the doctor's orders did not seem appropriate in the situation.

10: "The doctor walked in and said 'O.K. we need a continuous tracing in here'. All of a sudden, we were just going from normal to abnormal within seconds, which neither of us (the woman and the midwife) liked. The two of us, I was even getting my back up thinking well everything has been normal so what's the problem?"

This doctor seemed to perceive this situation as one of risk, a view not willingly supported by the midwife. Rather than ask the midwife about the situation to get a clear picture of both the progress of the labour and the woman's wishes, the decision as to the best course of action was made without consultation or discussion. The decision was communicated to the midwife in front of the woman and her partner, leaving no opportunity for private discussion outside of the room. The midwife would be in a difficult situation, not wanting to demonstrate conflict with a medical colleague

but feeling that the decision was inappropriate. The paternalistic approach, in a risk management culture, led the doctor to believe he knew the best course of action in this case from an objective position and that he was acting in the best interests of the woman. The midwife and woman together were 'getting their backs up' probably not so much by the actual decision (as this was a case with light meconium staining in the liquor) but in the way it was ordered.

A further midwife described a situation in which a more senior midwife made a suggestion which was felt to be unhelpful. In this situation, the midwife resisted the 'order' but felt that it had interrupted the positive feeling in the situation nonetheless.

2: *"The only thing that was a bit disappointing was at the very end when the other midwife came into take the baby, it was obviously a big baby, I knew that everything was going to be okay though but the midwife who came in actually said three times you must give this woman an episiotomy. The head was taking a while to come up but I felt it, I'd been there with her for so long, I felt that everything was fine, I really did and it was. She did have an intact perineum but she (the other midwife) said three times... that this woman needs an episiotomy and I was glad that I didn't give her one. I felt that it was inappropriate to have done one and I was being told to do one and this midwife didn't know this woman, she hadn't been there to build up a rapport and relationship or any feelings about how things were going."*

This situation is likely to have been a very uncomfortable one for the midwife delivering the baby and may have been quite frightening for both the woman and her partner, if they were aware of the conflict. The midwife was able to hold her own and not bow to the demand of her colleague, a decision which proved to be in the woman's best interests. Midwives do not always feel able to stand firm in such situations, it takes a great deal of confidence to go against the decision of a more senior colleague. At times, midwives need allies to help them to be strong at times of challenge or conflict.

In the following situation, the midwife was rescued from unhelpful doctor's orders by a more senior midwifery colleague.

12: *"That's one of the problems at maternity unit X because the medical people get.. it's really hard, I find it hard when I'm on a strange labour ward to stick up for myself and the woman with the doctor. I know there was one time when I felt really cross with myself; it was when Midwife T was around on the labour ward. He's a person, whether right or wrong, who will stick up for himself. Anyway, I went into look after this woman and the trace wasn't ideal, I can't remember if she was post term but there was thin*

meconium and it wasn't disastrous but it wasn't ideal. This woman had been on the monitor all night and I thought she needed to get up and have a shower and feel human. It wasn't the sort of trace where you'd be terribly worried if she was off for twenty minutes but she was somebody who you would want to monitor pretty carefully but I didn't feel that anything disastrous was likely to happen in twenty minutes or so. I was going to take her off the monitor so she could go to the shower and around came this registrar who said 'oh no, she has to be on the monitor the whole time!' and I just thought 'oh this poor lady'. Then Midwife T came around and he said 'Lynn, aren't you happy' and I said 'no because I wanted this lady to be able to get up to the shower and I've been told by the registrar that she must be monitored the whole time'. So Midwife T went and told the registrar that the midwife was extremely well experienced and that she wouldn't put the mother and baby at risk. He then came back and said 'Lynn you can do what you want!'. So I got her up in the shower and she progressed much better after that. It's hard if it's a doctor you don't know, if you're in a strange unit, it's hard to negotiate and it undermines your confidence."

This lack of confidence is an important issue if the midwife does believe that she should or is able to make sure things go well. Assertiveness is necessary to deal with situations where the orders being given do not seem appropriate to the midwife; the descriptions above do not indicate an ability to negotiate effectively on behalf of the woman. These midwives appeared to be in relatively powerless positions with little confidence in their ability to advocate on behalf of the women involved. One midwife described her role, once the doctor was involved, as a mediator or almost translator:

10: "I was giving her time and discussing with her, although we didn't have a lot of time, we were able to discuss what was going on. I was able to give her full feedback. The doctors were coming in and they were saying things and then walking out; I was able to stay with her and say 'This is what's happening. Do you understand what's going on?'. They were able to talk to me and ask about what was going on."

This is a very important role so the woman feels informed through stressful situations. But it is not the role described with the idealistic words 'making sure'; it is a subordinate role to that of the more senior medical or midwifery colleague in cases of complication. The comments made by these midwives indicate that they take a metaphoric step down when other senior members of the team become involved in care; they defer to the seniority although they may not agree with the decisions.

Two midwives discussed the issue of managing risk, or potential rather than actual complication, through the use of protocols. This appeared to be another way in which the midwife's professional decision-making was compromised by others.

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10: "What I understand of risk management and risk criteria is basically that we have this protocol in our unit to guide us when there's a problem...If this is wrong, you have to do this...But, I think, for example, something like term meconium, you don't need a continuous tracing all the time if everything has been normal but to them you do, because it's risk management. I don't know. I think we need a review."

8: "You can say that protocols are only guidelines but, if you don't use those guidelines, you have to be very able to justify that. I am not going to go for that. We have to have safety nets and standards but let's not fool ourselves; we are not completely free entities that can do as we please."

The risk management culture prevalent in the current NHS (as considered in chapter three) has led to practice being controlled through rigid guidelines in many maternity services. In some cases the guidance is evidence based and developed with multidisciplinary participation; this is likely to make the guidance more acceptable to both midwifery and medical staff. However if the guidelines / protocols are dictating an approach which is not acceptable to the woman or which may lead to avoidable intervention, midwives may feel frustrated and constrained. Midwife 8 seemed to feel that she should be able to practice as she chooses, using her own judgement, without having to provide justification for the choice, but recognises that this isn't the case. She appeared reluctant to have to clearly articulate her rationale for the chosen approach to practice, an attitude which may not be helpful to her cause of professional autonomy.

In the cases of either direct interference by other professionals or indirect through protocols, the midwives interviewed did not portray an impression of being in control. Their roles in a large bureaucracy seemed relatively powerless in relation to more senior colleagues. Despite this relative powerlessness, the midwives interviewed did seem to feel a sense of responsibility for 'making sure' that the outcome was satisfactory. The definition of satisfactory, of course, is likely to be different by the various players in the scenario. As highlighted in the discussion about 'preparing', the midwife's idea of satisfactory may not be identical to the woman's. This poses challenges with the need to address expectations. Midwives might be trying to 'make sure' things go as well as she / he expects they realistically can. However this may not match the woman's ideals. The inability to ensure women had the experience of their

dreams led to some of the midwives interviewed feeling that they had let women down. They weren't able to make sure the woman got the experience of her choice.

Guilt / Feeling You've Let Her Down

Several of the midwives shared the feeling of guilt which was experienced in a number of situations:

1: "I don't know why you should feel guilty but I usually do, I can't explain it, even if you weren't involved, you feel that maybe there's some way in which they should have been prepared more, that they weren't prepared at all for a difficult birth, even though you've done your best in your antenatal classes to give them the whole picture."

2: "I don't know if it's guilty or inadequate whenever they have to have an assisted delivery. I know in this case it was totally appropriate; I do feel that she probably would have delivered eventually herself but that baby would not have come out in a good condition because.. I know you can't tell but if you're are tracing somebody and the trace now is poor and getting worse and there is meconium draining, the delivery isn't imminent, you can't just let it go on and on. There has to be a point when you.. I think she would have done it and maybe everything would have been alright but you never know, it's unanswerable."

4: "Even though I know that there was nothing else that I could have done in my practice to have changed it. Often these things happen and it makes you wonder about monitoring. But I know there was nothing else I could have done differently that would have changed the outcome really. The baby is fine and it soon picked up but somehow it still makes you feel guilty. You think that there must have been something you could have done to change it but in actual fact there wasn't. I was watching everything as you normally would and there was no sign that the baby would come out like that, but it does make you feel bad." (situation in which the Apgar score was low at birth but there were no warning signs in labour)

These midwives appear to be defensive about situations where complications have arisen. They are saying that it is not their fault, in situations where a different outcome may be unlikely, but they lay the burden of guilt on their own shoulders. This is supported by Stapleton et al's (1998) findings of guilt and blame as themes in the current culture of midwifery. In their study relating to midwifery supervision, they found that even when situations were not within the control of the midwife, appropriation of blame and feeling deserving of punishment in some way were common reactions. They postulate that this seems to be learned behaviour which is deeply ingrained and largely not recognised as problematic by midwives. Some of the midwives I

interviewed did seem to feel that they personally had let the woman down if things did not go according to the woman's wishes and blamed themselves with no hesitation.

In one case, a midwife was discussing a situation where she felt she had done all she could but the woman was unable to push the baby out on her own.

4: "In terms of the birth, I remember I had one, probably a couple of years ago, when I was still on labour ward. I think I was qualified for about a year but it was the first time I'd come downstairs from the ward to labour ward. I had a lady that was pushing and had an epidural and maybe I didn't have the skills or experience to encourage her to push as well as I could have got her to with the epidural. I did tell her that she could do it, that many women push out their babies with an epidural. But maybe I just didn't give her the support that she needed cause she did end up with an instrumental delivery; maybe if I'd been a bit more supportive and really got into it, and made her push then maybe she might have delivered herself rather than having to have one of the doctors deliver the baby."

I asked this midwife whether the mother had known that the incidence of assisted birth goes up substantially with epidural analgesia (MIDIRS 1996). She was unsure as she had taken over this woman's care part way through the labour and she had not talked to the woman about this evidence and was unsure as to whether the other midwife had. It led to a discussion, in the interview, about what information women need to be able to make choices in labour. Despite recognition that there is research evidence about epidurals and assisted births, the midwife brought the responsibility back to her own inadequacies:

4: "I used my skills but maybe I should have got myself more together and believed that really she could have done it. I did encourage her but perhaps I should have been more encouraging and really have been behind her and thought more positively and said 'yes you can do it'. Maybe it was because I was more junior. I mean everything was fine, the monitoring was fine. It made me think that I didn't do the best for her that I could have done better really."

She highlights two important issues - she possibly did not really believe that the woman could do this without assistance and she internalised the reason for this rather than looking at fairly conclusive external evidence as for the cause. There was another scenario described where there is evidence which, if used, may have led to an improved outcome.

9: "Well she had a two page birth plan of lavenders and baths, positions and really detailed of what she wanted. Basically she came in and had to be induced."

I: "Why was she induced?"

9: "Over dates. It took her ages to get into labour and then when she got into labour, she began to lose it then because things weren't going the way she wanted it to go. She had to be monitored then and once we hooked up to the monitor we then had to.. her contractions went off and she had to have Syntocinon, she had to have needles and she didn't like needles, she had to be strapped to the bed so she couldn't move around like she wanted to.."

I: "Did she have to be strapped to the bed?"

9: "Yeah because she was on the monitor; that's the protocol on labour ward for Syntocinon. She had an epidural then, see, and so she couldn't even sit in the chair. It was horrible. So she had to be on the bed all the time and she had to have a Ventouse and a big cut and it just all went to pieces... but then seeing her afterwards and just talking about it, she thought she had a tough time."

Although this midwife did not appear to blame herself for the unsatisfactory (as far as the mother was concerned) outcome, the protocol which was adhered to very literally in this situation may have interfered with physiological progress. Had there been more of an attempt to keep the woman active, the outcome may have been different (MIDIRS 1996b). There appeared to be no recognition that the midwife could have tried alternative methods of helping this woman to achieve her goal. She may have lacked the skills of supporting physiological birth and both the confidence and knowledge to be able to challenge protocol driven care and to effectively use the best available evidence in her practice.

There were other midwives who blamed themselves for not being effective, not making sure things went as the woman would have liked.

4: "There are others where you don't do an episiotomy and then the woman has a bad tear and then I feel really guilty as well. You just can't win some times. You think that maybe it would have been better, but then again there was no indication but maybe the perineum was tight and wasn't stretching.. I very rarely do episiotomies only when you can see it's beginning to tear or if there's fetal distress."

12: "I think that midwives certainly can feel guilty, if they.. I suppose some of it's with hindsight, you can sort of think 'I wish I'd done so and so; I should have augmented her earlier, she wouldn't have had that prolonged labour' things like that. Or you might think 'I wonder if I'd done so and so, maybe she wouldn't have needed an epidural'; you can feel guilty but you only work as a midwife if you want to help the woman have the experience she would like. But sometimes, when you reflect on it, it was just unavoidable, she'd got a face presentation or whatever it was and you'd made the best

of whatever it was. But, then other times, you think there were things that perhaps you could have done."

Despite the more philosophical approach described at the end, by the last midwife, she then provided a scenario in which she felt she had been ill informed and it had had a negative impact on the woman. This had made her feel guilty.

12: "I can remember slightly over stimulating someone at Maternity Unit Y once, which I felt slightly guilty about, speaking of feeling guilty, because at that unit they have syringe pumps for Syntocinon and I was used to 10 units in a 500 ml bag. I mean I turned it down when I realised that she was over stimulated but I didn't have the feel for this syringe pump in the same way as I would have with the bag. I thought that the woman wouldn't be too pleased with me because she was having more pain than she needed to."

She clearly blamed herself for not having the knowledge of the approach in this particular maternity unit, possibly appropriately. There were some comments where the midwives felt inappropriately blamed by others.

7: "Actually the baby was fine but I felt awful and then the sister in charge said I should have rung the bell to get her. She said 'you should not have dealt with all that by yourself' and, by saying that, I felt she was blaming me. When things happen, you think 'well, it wasn't that I could not cope with the situation'... but she said 'you should not have let the paediatrician leave the room, you should have gone and got the bottles yourself'... I felt awful."

12: "I've had one (third degree tear) with a shoulder dystocia and they said 'Why didn't you do an episiotomy?" and you think 'why should I do an episiotomy?' There's no need to do an episiotomy but they just think you should do one.... I get angry with that criticism if it's not warranted."

This 'blame' behaviour may be part of the horizontal violence (Leap 1997) described in chapter two, where there is lashing out at colleagues by members of oppressed groups. These midwives had made decisions which were not considered appropriate by colleagues; rather than a reasoned discussion about alternatives, they felt they had been reprimanded for making the 'wrong' choice. The paternalistic approach of the sister involved, in the first scenario described, may have undermined any confidence that midwife 7 had. In the second scenario, blame appears to be attributed in the absence of a reflective review by peers of the outcome and other ways in which the case may have been handled.

One midwife appeared to have the confidence to accept the limitations of her impact on certain situations.

10: "I do think, a lot of midwives, feel guilty about tears. I haven't been in midwifery a long time but I have been in long enough to know that it's not my fault. At the end of the day you do your best but sometimes it's the babies fault! Like if they come out with a hand beside the head, you can do your best to control it but at the last part of the second stage... you just do your best although your best may but always be good enough but you have to accept it."

In addition to feeling guilty themselves, the midwives highlighted situations in which the mother herself felt disappointed by the outcome or even guilty about it. There appears to be a parallel between midwives and women in these cases, where both seem 'set up' for guilt or shame if things don't go according to plan.

12: "She actually progressed in labour well but when she came to push, she couldn't push the baby out and it was a real problem. It was everybody's fault.. she got very aggressive with her husband and she got very aggressive with me and it was quite evident that she was not going to do it, the trace was getting suboptimal, it was tachycardic and then the meconium started to drain and I didn't feel happy and I think she needed an assisted delivery and I was very disappointed that she did need an assisted delivery because she was the kind of woman she was, I think she really needed for her to be able to deliver the baby herself and I think at the last minute, it was taken away from her. "

11: "I know for a fact that, postnatally, she was feeling really sort of fed up that all of her plans from the beginning of the pregnancy, that she had communicated with friends, which I think was the problem because she'd told everybody that she was going to have a home birth and then a water birth and everybody was in awe of it. Then she ended up having an epidural and Ventouse delivery and then she was in here for two or three days whereas she had expected to have a nice, normal delivery at home."

13: "Because what happened was that when she came in, she had all the ideas of natural childbirth, as natural as possible, but it went on and on and on and everybody had said to her that as she had progressed so well, she should deliver by a certain time. But when you come on, you see that she's really very tired and no one has explained to her that she should have an open mind and that she should give it another go, go for something else. Since you are not coping, why keep struggling on? I know as a midwife you want it as natural as possible, I've gone through it for one, so I said to her to have an open mind, to try an epidural and see how you feel. So she tried it and she said it was a great thing that she had. You can see the relief because she kept thinking that she had let herself down and she had the guilt and she was letting

the husband down. But she was not going forward and everything that was planned in her mind didn't go that way. It's the guilt that they have. And then they suffer with the pain and it's just not on."

This goes back to the issue of realistic expectations but also highlights the judgmental attitude of some midwives, in cases where women set goals which are not achieved. As discussed on page 185, in these situations, the midwives almost seem to be blaming the women for having wanted something which is too idealistic. There appeared to be little attempt to make sure the woman got what she wanted; the efforts went into changing her expectations. This may be as a result of the midwives not having the skills necessary to mediate on behalf of the woman, to ensure that the woman was protected from unnecessary or unwanted intervention or distraction. However the midwives' skills and resources in this area were not specifically explored in the interviews. The fact that they elected to alter the woman's expectations rather than modify practice or the environment may indicate that this seems the path of least resistance in a large bureaucracy. Modifying the common practice in a maternity unit to suit the needs of an individual would take confidence, assertiveness and energy.

There is a current theme appearing increasingly frequently in the midwifery literature, that of 'keeping birth normal'. Page (2000) identifies three key elements, based on a review of best available evidence, which may help to keep birth normal. These include the use of intermittent auscultation rather than continuous electronic monitoring of the fetal heart in labour, helping women to cope with the pain of labour to reduce use of analgesia in general (and especially epidural anaesthesia) and the constant presence of a trained companion / midwife throughout labour. The practice described in the scenarios by these midwives did not appear to based on these standards; electronic fetal monitoring and epidural analgesia were common occurrences in the labours described. It seems likely that these women did not realise the negative impact of some of the choices made about their labours; they may not have been given the evidence from which to make informed choices.

It may be that midwives are not aware of the implications of their actions in withholding information from women. The lack of recognition of their relative power over women (as discussed in chapter two) may play a significant part in this. They may not believe that they have a significant impact on the woman as they themselves feel relatively

powerless. Also, there may be a lack of belief that they can really make a difference to the outcome for women through using evidence. They may rely on alternative strategies to try and 'make sure' all goes well. The strategies which these midwives employed included modifying the woman's expectations and accepting personal blame for outcomes. It would also seem that some midwives attribute blame for outcomes to colleagues rather than considering whether the support provided was effective and evidence based.

There was one midwife who described what appeared to be a coping mechanism for dealing with her personal disappointment about a change in circumstance. This woman had planned for a water birth; complications arose and other members of the team became involved. The midwife described herself as having become 'detached' from the situation.

10: "She was able to listen to me and then the experience at the end, she ended up with a Ventouse so it wasn't actually a very happy delivery at the end. It wasn't the experience that she wanted but she was quite happy at the end of the day, that the baby was well and she was O.K. I ended up detaching myself a bit at the end cause I'd been up all night but I still felt when I transferred her up to the ward in the morning, there was still a lot of goodwill between us even though she didn't have what she wanted. She still got her beautiful daughter but she didn't have the delivery that she had wanted."

These stories are in contrast to the earlier 'special' ones. In these cases, midwives were not able to make sure that everything was alright; complications arose and there was a feeling of disappointment in some, guilt and blame in others. The feeling of guilt may come from an unrealistic assumption of responsibility (often without the power to be effective), in believing they should be able to make sure that birth is normal. It would seem that these midwives are not really able to effectively keep things normal with the approach to practice in the maternity unit where the study was conducted. This may be as a result of not using best available evidence, of being constrained by protocols and procedures or of feeling blamed by others when things go wrong. There appeared to be a lot of energy going into adjusting expectations rather than in trying to fulfil them. All of these issues combine to create a stressful environment in which it may be very difficult for midwives to achieve their ideals.

<u>Playing God</u>

Two midwives highlighted the continued paternalistic perspective in medicine that the professional knows best and wants to protect the ill-informed public (i.e. wants to be able to 'make sure').

14: "if you're there looking after a woman but if the CTG, the heart rate is going down, going down, going down and there is thick meconium and the woman won't consent to a Caesarean section and you know the right choice..."

12: "I suppose it's always this thing that midwives want to protect women to a certain extent and you have a balance in mind between keeping women fully informed; we've still got some of this paternalistic thing from medicine I suppose where you want to protect someone from the worst scenarios."

However two others posed questions about whether this is an appropriate approach to care.

10: "I think that sometimes we expect ourselves to be gods, that we can do everything, a sort of miracle worker."

8: "So what I'm saying is maybe we should not be playing God and maybe we should be inviting the women into the decision making process more."

Unfortunately, the evidence from the interviews presented appears to be that most of these midwives feel that the outcome does have a lot to do with them yet do not use evidence-based practice to help women achieve their dreams. As one of the midwives suggested, perhaps they do not really believe that women can do it.

Conclusion

These interviews provided rich data about a spectrum of issues in contemporary midwifery practice. The midwives themselves highlighted several important aspects of practice that may relate to the artistic side of midwifery - rapport, relationship, communication, preparing and supporting. They told stories of births which had been positive and satisfying for both woman and midwife, special experiences which they appeared to cherish. They demonstrated a caring attitude and a real interest in their chosen occupation. However, they also told stories of situations in which they feel they failed women, where they weren't able to make sure that everything went as the

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woman wanted. This appeared to be for a variety of reasons - they felt comparatively powerless when another, more senior health professional (midwife or doctor) entered the relationship with them and the woman; they no longer felt in control yet, paradoxically, they felt a responsibility to be in control as expressed in the term 'making sure'. They felt that they could be blamed for aspects of their practice and that choices were constrained by protocols and guidelines. They did not appear to use the best available evidence as a tool for optimum care. They did not appear to really trust women and believe that they can achieve their dreams with appropriate support.

The current position of midwives, as presented in the discussion in chapter two on the history and profession of midwifery, sets a scene in which these findings are not unexpected. Midwives, despite being considered as 'practitioners in their own right' by regulating bodies, may be constrained by colleagues including Supervisors of Midwives, midwifery managers, other midwives and doctors. Although they seemed to want to believe that they really could make a difference for women in their care, these midwives did not achieve that outcome consistently due to a variety of pressures. There seemed to be a lack of recognition of their relatively powerful positions in relation to women and of the potential in a true partnership approach to care.

This part of the study highlighted a number of important positive elements of midwifery which would need to be integrated into a programme of preparation for midwives. However, the relatively disempowered position of these midwives would not necessarily set them up as helpful role models for student midwives, if pre-registration education is to prepare midwives able to help women achieve their goals, despite the prevailing culture. Recognising the evidence about the importance of learning in practice discussed in chapter four, I wanted to think about how this could be overcome. I knew that there are midwives who are not constrained by their environment in the same way as many of those interviewed in this stage of the study. The logical next stage seemed to be to interview some of those midwives, to learn how they had managed to practice in a very different way.

Chapter Seven

The Autonomous Midwives

Introduction

This chapter will present the findings from the second group interviewed, a group of midwives whom I have labelled as 'autonomous'.

> Historically the word 'autonomy' has derived from Ancient Greece, where 'autos' (meaning self) and 'nomos' (meaning rule or law), were joined together to refer to political self-governance in the city-state. Words such as self-rule, self-support, self-sufficiency, liberty, freedom, power and authority give an indication of the meaning of autonomy, but nevertheless it is indeed a very complex concept with unlimited theoretical dimensions.
>
> Marshall JE & Kirkwood S 2000:127

This definition of autonomy, out of many possible ones, encapsulates the characteristics of the nine midwives interviewed, appropriately for my purposes. This group of midwives are all working in areas of midwifery where they have an ability to self-govern far more substantially than those in the initial interviews. Sargent (2002:41) places the concept of autonomy into the real world of midwifery by suggesting that "the midwife who is able to practice using the full range of her skills and knowledge and who can plan and execute care for the woman" is working autonomously. She suggests that the essence of autonomous midwifery practice relates to the capacity for decision-making (Sargent 2002); that is, the ability to effect care that meets the needs of the woman despite the prevailing norms within which practice sits. This takes confidence and assertiveness as well as the knowledge to underpin professional judgement. The ability to self-rule when working as a part of a multiprofessional team, especially in a role which is relatively powerless in that team, sets a serious challenge for midwives. The group interviewed in this part of the study demonstrated this confidence and the capacity to work with others to the woman's benefit in a very autonomous way.

This chapter will begin, as the previous one did, with a description of data collection method used in this part of the study. The demographic details of the interviewees will be presented and then the categories and the theme which emerged from the analysis will be discussed with reference back to the findings from the initial interviews.

Data Collection Methods

Data were collected from these nine midwives in very opportunistic ways. As some live overseas and were only visiting the U.K. for a short period or had intense work commitments, I had to meet them in ways which would fit in with their availability. Therefore I have conducted two group interviews, using the technique of focus group interviewing discussed in chapter five. For others, I was able to meet them individually and therefore used the approach to individual interviews also discussed in chapter five. In all interviews, I started the discussion by presenting the themes which had emerged from the initial fourteen interviews, undertaken in phase one of the project, and by asking how they felt they were able to become autonomous in their practice, as I had selected them as an 'autonomous' sample.

The purpose of collecting data from some 'autonomous' midwives was to raise issues which had appeared in the initial interviews, especially relating to the powerlessness which underpinned the initial midwives' practice. I wanted to find out how this second group had been able to develop the confidence to practice outside of the usual health service model of midwifery and to be more self-governing. I asked them to tell me about their practice and their beliefs, and tested their feelings about the issues raised in the initial interviews. They painted a very different picture of midwifery.

Profile of the Autonomous Midwives and the Process

The sample of 'autonomous' midwives comprised nine midwives who were practising or who had practised midwifery outside of the 'usual' system of British maternity care. One had been an independent midwife in England and had recently moved to Australia, one was a midwife from Canada instrumental in gaining legal status for the profession in Ontario, one was a renowned Australian midwife and one well known in New Zealand, four were caseload holders in a continuity of carer project and one was a lecturer who had led the caseload project. Although it was not essential that this sample should be well known midwives, they were asked to participate in the project because they were recognised as autonomous, being known to both myself and my supervisors either personally or by reputation. In certain respects and with the beauty of hindsight, it may have been preferable to find midwives working within the traditional

British system who were also autonomous in their practice. However, it would have been very difficult to find such a sample. Therefore, to a certain extent, this sample is defined not only by their autonomy but also by their place of employment and status. This is an important factor to be considered in the analysis and comparison between the two groups.

These interviews took place as two focus groups (one group of three and one of four) and two individual interviews due to availability of the midwives. They lasted for similar lengths of time to the initial ones, approximately forty to sixty minutes each. These interviews were annotated rather than taped and transcribed (I did try to tape them but the group interviews were very difficult to hear therefore I used the tapes to confirm my notes rather than to produce full transcripts). I recapped from my notes at the end of each interview and the midwives were asked if they agreed with my understanding of their words. They all validated that I had a correct understanding of the issues they had raised. The data they provided gave a contrasting dimension to the emerging themes from the initial interviews.

The midwives were not dissimilar in age profile to those in the initial interviews but had somewhat different training and current work experiences from the earlier ones. Two of these midwives had trained as direct entry students, not having undertaken nursing before moving into midwifery. Although four of them were working within a maternity service in Britain, it was in a caseloading scheme where they were able to provide continuity of carer. The others had moved out of the maternity services, three working in universities (one carrying a caseload in practice as well as lecturing), the fourth working in a consultancy capacity, doing project work in maternity services, and the fifth undertaking caseload practice in another country.

The breakdown of interviews is as follows:
Interview 1 = participant 1 (individual interview)
Interview 2 = participant 2 (individual interview)
Interview 3 = participants 3, 4 & 5 (focus group)
Interview 4 = participants 6, 7, 8 & 9 (focus group)

Autonomous Midwives

Participant	1	2	3	4	5
Age	41	39	50	47	49
Trained	Texas	London	London	Sydney	Adelaide
Qualified	1988	1982	1982	1979	1971
Area of work	Caseload	Uni/ Caseload	University	Caseload	University

Participant	6	7	8	9
Age	30	34	35	49
Trained	London	London	London	London
Qualified	1991	1991	1991	1986
Area of work	Caseload	Caseload	Caseload	Caseload

Analysis

The approach to analysis was similar to that for the initial interviews; I typed up my extensive notes, coded the comments and started to build categories from the data. As the notes did not include every word spoken in the interviews, I had to be careful not to fill in gaps with my own thoughts but to focus on the actual text. I had captured a number of particularly important phrases in my notes; whenever the interviewees made significant comments, I wrote down their exact phraseology so I would not lose the sense of their thoughts. This has been very helpful in determining the categories and theme as, despite not using complete transcripts, I have been able to use their words to define some of the categories. The data were much more succinct and focused in these interviews than in the initial fourteen as the discussions were centred around the themes from the first stage. Some of the analysis seemed to start during the interviews as these midwives were very able to analyse their perspectives on midwifery and from where these originated.

The interpretive approach of grounded theory analysis recommended by Glaser (as described in chapter five, Levy 1998) was used, with questions being posed in relation to the data to establish a clear sense of the meaning. There was a distinct difference in both the words used by these midwives and the way in which they used them from those in the initial interviews. There was never a feeling that they might be saying what I wanted to hear; there was passion in the way they spoke about women, birth and midwifery. It was an inspiring experience to interview these midwives and I felt very different from the way I did when undertaking the initial interviews. The midwives in the

first group had made me feel sad that they felt unable to achieve consistently their or the women's ideals. This group made me feel enthused and invigorated, reaffirming many of my own ideals for practice.

Findings

As I have identified, the data in this stage of the study were more concise than those in the first stage. The questions I asked were focussed on their thoughts on being 'autonomous' and on the themes which had emerged from the initial interviews, providing much more targeted responses. It was easier to extract significant concepts in many respects and lead to a succinct framework of codes, categories and one overarching theme. In presenting these findings, I will include quotations where my notes had captured a complete phrase or sentence as well as paraphrasing some of the comments which I did not have in entirety.

Codes	Categories	Theme
Women can do it		
Feminism versus femininity	Believing in women	
Community spirit		Believing
Knowing what the woman wants		
Politics		
Role modelling	Believing in yourself	
Refer not defer		
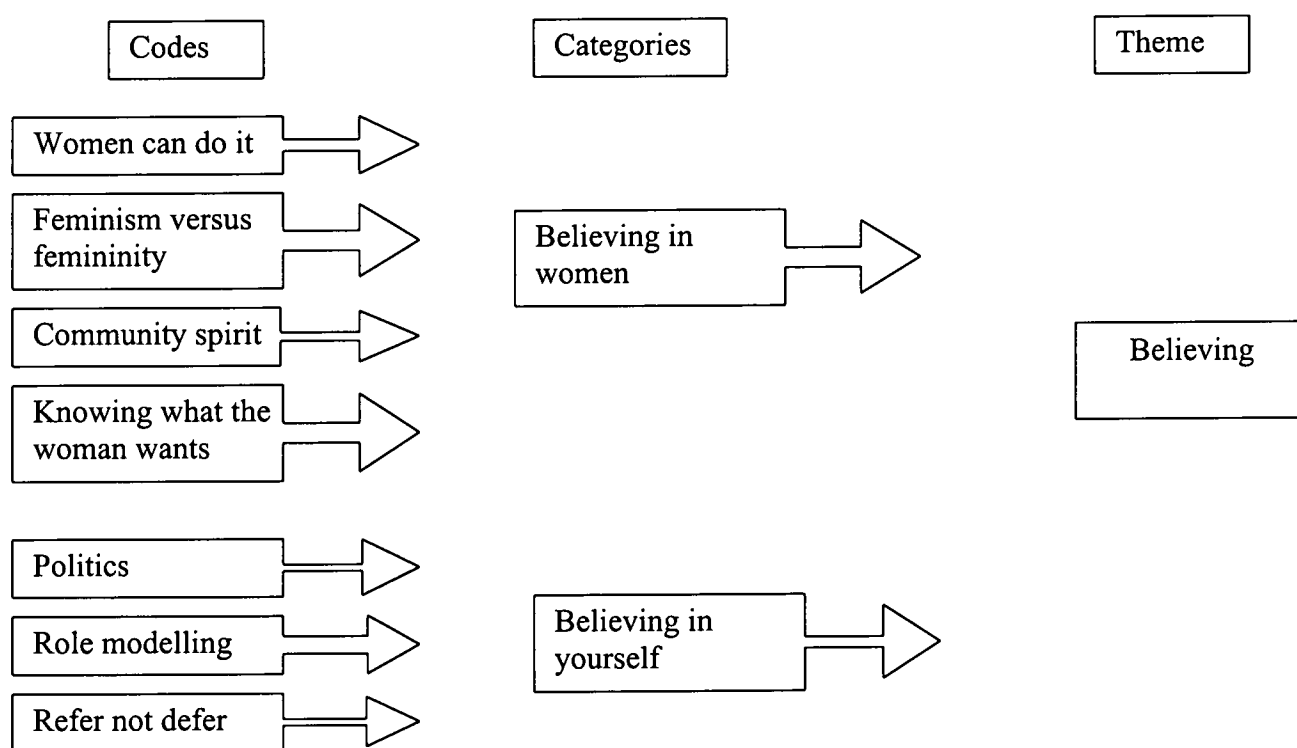
Believing in Women

The first four codes from these interviews demonstrated a confidence and trust in women, a belief that they are able to birth without intervention given the right conditions. The role of the midwife seemed less active in these interviews than it had in the initial ones; it was focused on ensuring that the woman gets what she wants.

<u>Women Can Do It</u>

Although this sentiment was implicit in all of the interviews, in the third interview in particular, there were comments which highlighted the midwives' belief in women's capacity to give birth, relying only on themselves and their inner resources rather than on external support from midwives or doctors. They expressed a belief that 'women can do it'; they are able to undergo the intense, physiologic process of birth without medical or technological interference. However they also recognised that some midwives find it difficult not to interfere in some way.

3: *"Believing in women rather than in us or anyone else (including the all powerful medical intervention) means we need to recognise that crutches are not necessary."*

This group raised two key points in this statement- believing in women is critically important to midwifery and that, despite this, some midwives use 'crutches' to make themselves feel useful or perhaps important. This second point was further expanded:

3: *"Doing things, for some midwives, is important to autonomy... you have to do things (not necessarily traditional interventions but interventions nonetheless) like sweeping membranes, massage, complementary therapies, herbal compresses on the perineum. These all undermine the woman's own capacity, her belief in herself. It replaces a medical crutch with an alternative one but it is still a crutch."*

This suggests that there are midwives who do not believe that birth can be accomplished without some sort of external support or action. However the three midwives in this interview recognised that reliance on intervention may strip the woman's confidence in herself; the implication is that the midwife needs to believe that intervention is unnecessary to be able to help women believe in their own resources. There is a fundamental need to believe in women in order to be effective as a supporter of birth. These midwives demonstrated their belief in women clearly in the interview. When asked whether they saw part of the midwife's role being to 'make sure' as the initial midwives has raised, their reply was that this is not only impossible but another element of not believing that women can do it on their own.

Flint (1995) identified that there have always been two opposing views on childbirth; one that nature can always be given a helping hand (and presumably this would lead

to increased efficiency in the physiological process) and the other that nature should only be meddled with in dire emergency. These two perspectives remain very prevalent in the current maternity services. Examples of 'lending a helping hand' from current practice will be considered to identify why midwives might feel the need to intervene as part of normal care.

One especially pertinent example of the first view described by Flint is that of the active management of labour. The move to actively managing labour (O'Driscoll et al 1984) came about as a result of the belief that the birth experience is improved if accelerated through medical intervention. Following O'Driscoll's seminal work in Dublin in the 1980's, a series of trials have followed to determine the effectiveness of the approach (for example, Turner et al 1988, Akoury et al 1988, Lopez-Zeno et al 1992, Fringoletto et al 1995, Sadler et al 2000). All of these tried to identify positive, measurable outcomes as a result of early amniotomy in labour, frequent vaginal examinations to determine progress throughout labour, and oxytocin augmentation to maintain strong, regular contractions if the cervix dilated more slowly than one centimetre per hour.

Maternal outcomes investigated in these trials included the Caesarean section rate, length of the first stage of labour, risk of prolonged labour (more than twelve hours) and postpartum haemorrhage rates. The results have been somewhat different in the various trials; two found the Caesarean section rate to be lowered when labour is actively managed in nulliparas (Turner et al 1988, Akoury et al 1988) whereas others found no significant difference in this rate. Most found the length of the first stage of labour to be shortened (O'Driscoll et al 1984, Lopez-Zeno et al 1992, Fringoletto et al 1995, Sadler et al 2000) but few actually tried to measure whether this outcome led to increased satisfaction for the labouring woman. Sadler et al (2000) did look at satisfaction levels and found there to be no difference between the women with the actively versus routinely managed labours. The method of measuring satisfaction were two questions on a questionnaire sent to the women in the trial six weeks postnatally. The questions were: "Thinking back now, how satisfied are you, overall, with the care you received during your labour and delivery?" and "Would you choose the same type of management again?". The women were given a Likert scale of possible replies to these questions; both the study group and the control group provided similar responses. However these women were all nulliparous; they had no basis of

comparison from which to draw for rating the experience. The questions were very global in their spheres without identifying specific parameters of either the care received during, or the experience of (for example, feeling in control, meeting expectations, feeling supported, pain, etc) the labour which may have helped women to be more critical of the experience. The findings from the trial regarding women's satisfaction may have limited value on these bases. Unfortunately, despite these limitations, the somewhat restricted findings of this and other reports have been used to justify the widespread use of active management as a virtually routine approach to support in labour in the U.K.

An additional, interesting finding from this trial (Sadler et al 2000) is that the active management protocol was not followed strictly in forty percent of the women randomised to active management. The researchers claim that this may be because the midwives were not comfortable with the high doses of oxytocin prescribed and so they did not comply. "A number of the midwives considered the active management protocol to be medical interference and thus contrary to the philosophy of midwifery" (Sadler et al 2000:915). This is reminiscent of Statham's 'doing good by stealth' discussed in chapter six. It may have interfered with the validity of the findings of this study and also may have been a feature of other similar studies that was not reported. Some of the midwives in the maternity unit where the study took place would seem to have had the view that nature does not need to be meddled with unless there is an emergency. However it begs the question as to why the midwives agreed to participate in the study in the first place. They are appearing to comply with the protocol by randomising women into the categories but then manipulate the randomisation by not adhering to the management strictly. This passive resistance would presumably have affected the findings of that study in a way that may have overestimated the satisfaction women experienced in the active management group. The midwives were attempting to do the best for the women but did not challenge the source of intervention in a collective way. They would seem to be confident in knowing what is best for women but less so in being able to challenge medical opinion.

In relation to midwifery confidence, Shallow (2001) found in her study of midwives' views of their confidence and competence that some midwives fear labour ward and use tactics to avoid working there. One of the midwives she interviewed said:

What terrifies any of them? What is it? Is it a feeling of inadequacy? That they are not in control? (That they) don't fully understand the birth process themselves? So therefore they feel insecure? I don't know.

Shallow 2001:239

There are some important issues raised in this statement. This researcher points out two key possibilities for why midwives might be fearful in labour ward. The first relates to their position of relative control; the second relates to their understanding of the physiology of labour and birth. The context in which the midwives in Shallow's study were practising was a new system of team midwifery. The midwives who had not had considerable experience in the labour ward found it very difficult to practice there on an occasional basis and to feel competent. Shallow (2001) suggests that midwives in the contemporary NHS have become familiar with routines of care in hospital and with the through-put, production-line mentality on labour ward. She goes on to say that there is conflict at the interface between 'servicing the corporate needs of the organisation and the needs of the women' (2001:243), reminiscent of the discussion about street-level bureaucracies in chapter two. Shallow suggests that midwives have been steered towards technological intervention in order to accelerate outcomes and be cost effective at the expense of 'those attributes that are at the heart of midwifery' (2001:243). Despite having relative power over the actual woman's experience, the norm of practice in a given maternity unit and the expectation that all midwives will comply with it may prevent midwives from truly being 'with woman'. This tension between the needs of the service and those of the woman puts the midwife in a difficult position. She / he may want to believe that nature does not need controlling but in an environment which makes intervention the norm, they may feel unable to go against the flow.

However the other issue raised in the quoted midwife's comment relates to an understanding of the birth process. Perhaps belief in nature can be more effectively translated into confident, supported action by midwives if the midwives really understand what is happening physiologically to the woman at any given point and are able to enhance rather than interfere with progress. For some midwives, who have never practised anything other than a technologically managed labour and birth, this belief may be difficult to engender. Mander & Reid (2002:16) point out that such

midwives may also have difficulty in "differentiating themselves and their role from their more powerful colleagues". The unique dimension of support and advocacy brought to the care of childbearing women would be lost in this case, as midwives would operate from the same position as medical colleagues. Midwives in this scenario might well be viewing birth as a 'disaster waiting to happen' in the same way as Bryar (1995) suggests obstetricians do.

Active management is one example of the view that 'nature can be enhanced with intervention' but there are others as well. The third stage of labour has been actively managed for decades in the Western world, leading to reduced blood loss at the time of birth. What has never been clearly identified is whether the blood loss is beneficial or simply not a problem to women, assuming it is a natural phenomenon. The length of pregnancy is also actively managed through induction of labour in women whose gestational period exceeds the norm. These examples further demonstrate the view that 'nature can always be given a helping hand'.

Objection to this approach has been raised by women over the past twenty years in Great Britain. There was a well-reported demonstration by 5000 women outside of the Royal Free Hospital in London in 1982 to protest against the takeover of birth by technology (Flint 1995). Beech (2002) identified a series of subsequent actions which have also tried to reduce intervention in childbirth including publications by:
   * the World Health Organisation in 1985 addressing the need for appropriate use of technology (WHO 1985)
   * the Association for Improvements in the Maternity Services (AIMS) in 1997 proposing the definition of 'normal birth' to exclude artificial rupture of membranes, induction or acceleration of labour, epidural anaesthesia and episiotomy (Beech 1997)
   * the National Sentinel Caesarean Section Report showing an association between acceleration of labour and Caesarean section rates (Thomas & Paranjothy 2001)

The need for these actions and publications arises as a result of the very prevalent intervention rates which have increased rather than decreased since the Royal Free demonstration. A collaborative report in 2001 found that only 16.9% of primigravid women and 30.1% of multigravid women in five maternity units in one area of England

had a 'normal' birth, or one with no intervention (Downe et al 2001). With these levels of intervention prevalent in the current maternity services, the opportunity for students of midwifery to learn to believe that 'women can do it' seem limited. The medicalised environments in which birth takes place are not conducive to instilling confidence in nature.

However, the autonomous midwives interviewed demonstrated a strong belief in women; they had managed to maintain that belief through many years of practice. But all of them had moved out of the medicalised maternity services environment; they had chosen to practice in ways where they were able to be autonomous and not frustrated by omnipresent intervention and lack of belief.

Feminism versus Femininity

This belief that 'women can do it' was not articulated in exactly the same way in other interviews but other dimensions relating to it were. Feminism was raised in the first interview; this related to the formal, macro political stance of believing in women. The interviewee (who was the one who has been instrumental in establishing midwifery as a profession in Ontario) suggested that feminism is an important part of the basis of midwifery. She pointed out that feminism is a politically accepted concept in Canada; what women want is considered as important as part of the political platform of major parties. This clearly helped in the legalisation of midwifery, as the female vote was recognised as significant to winning at the polls. This also seems similar to the changes which took place in midwifery in New Zealand, as discussed in chapter six, where the partnership between women and midwives produced a strong enough momentum to change the status of the profession.

The notion of women being able 'to do it' relates here not to individuals and their private birth experiences but to the group of women who believed that midwifery was an important source of support for birth which should be available legally and freely within the health system. This group of women must have believed in the ability to give birth without all the interventions of the highly medicalised approach in the Western world or there would have been little incentive to champion the cause of midwifery in order to have it legalised. They believed in themselves, each other and in midwives as important to their birth experiences.

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When questioned about the issue of feminism, participants in subsequent interviews agreed that gender is an important concept in midwifery. No other midwife referred to the macro politics of feminism but the micro 'games people play' was raised in two other interviews. In the second interview, the midwife said that she felt that femininity was equal to passivity and that some midwives were happy to take that role.

2: "I agree, there are games midwives play on delivery suite. They often flirt with the male obstetricians and they say that it's the only way to do it as it a male dominated environment. The only way to stand up to them is by playing games."

The midwives in the fourth interview also talked about games:

4: "There are gender games; female midwives get on better with male obstetricians and vice versa as they can play the game and banter to achieve the goal for the woman."

Both of these quotations reflect a manipulative approach frequently used by women when trying to achieve the desired outcome in an hierarchical male environment. Stein published a seminal paper in 1960s on the 'doctor-nurse' game and claimed that:

> The cardinal rule of the game is that open disagreement between the players must be avoided at all costs. Thus, the nurse can communicate her recommendations without appearing to be making a recommendation statement. The physician, in requesting a recommendation from the nurse, must do so without appearing to be asking for it.
>
> Stein 1978:108

Porter (1991) contested this somewhat with the findings in his participant observation study of power relations between nurses and doctors in a general hospital. He found that in addition to covert influence over the decisions which doctors made, nurses also overtly impacted on care decisions especially with more junior doctors. He postulated that the relationship between nurses and doctors may have become more equitable since Stein had proposed his theory but recognised that Stein's theory may have been based on acceptance of outward appearances rather than delving into the subtle manipulations which are often at play. Another possibility which Porter suggests is that all doctors in the past may have been treated with the same deference which he observed almost exclusively in the interaction between nurses and consultants in his

study. Despite the changes which he found with the interaction between nurses and doctors at some levels, a power differential persisted between the two roles nonetheless.

The subordinate role of nurses, and many writers include midwives in this discussion, is attributed to the reduced status of caring over curing as was raised in chapter two. Hugman (1991) describes the curing medical roles as 'virtuoso' with high social standing. The less prestigious caring role associated with nursing is linked to the mothering / nurturing role of women and is given little value in society (Hagall 1989, Littlewood 1991, Samuelson 1991, Carpenter 1993). The autonomous midwives interviewed described colleagues who played games with doctors in order to achieve things for the benefit of the woman from their position of limited status and power. They, however, did not put themselves in the same category, presenting an impression of being able to interact as equals rather than inferiors (this will be discussed further under 'refer nor defer'). They seemed proud of the work they did in supporting women and empowered in that role.

Community Spirit

The belief that women need each other much more than they need health professionals was an issue raised specifically in the third interview.

3: "Women need their own friends and companions, the midwife is not there to fill this role. The idea of community is very important."

The midwives in this interview discussed the way that midwives can act as agents of connection, to help women find other women within their community who are going through the same experiences of pregnancy, birth and motherhood. The role of the midwife was relatively passive in their description; she was there to help women learn from each other rather than to teach them or solve their problems for them.

3: "Midwives are there to help women access resources, to put them in touch with each other."

This approach is underpinned by a belief that women with life and birth experience have a very valuable role to play in supporting peers; midwives are the catalysts for,

not the source of, that support. The "community spirit" reflected in the discussion highlighted a sharing approach to practice where women's confidence is developed through her connections with other women. It also indicates that the midwives interviewed had the confidence not to feel the need to be in control, relied or depended upon. Their satisfaction in the woman / midwife relationship came from being there to support rather than to intervene when it was unnecessary. This seems quite different from the ways in which the initial group of midwives said that women were prepared for labour and birth, by giving them advice and by modifying the woman's expectations to meet the reality of opportunity within the service. In the initial interviews, the relationships described focused specifically on the woman and midwife with some reference to the partner; there was no discussion about connecting women within their peer group as a priority for midwifery practice.

This sense of community is an important issue for some feminists. Stanley & Wise (2002:63) discuss the value of women "meeting and talking in small groups in order to share personal experiences and feelings; women hear what each other are saying, they don't just listen and then ignore what is being said". The value of groups and groupwork as a feminist tool to increase the sphere of influence is explored by Butler & Wintram (1991). From their experience of facilitating groups of women, they identify that women's groups "can encourage women's self-expression, personal development and change through the process of group interaction" (Butler & Wintram 1991:44).

Although not discussed during the interview, one of the midwives in the third interview has used this concept of groups effectively in bringing antenatal and postnatal women together to share their experiences of pregnancy, birth and motherhood as a viable alternative to traditional health professional led parentcraft classes. In this model, the midwife may provide some answers to specific questions raised in the group but she does not lead it or take charge of the content of the sessions. The women gain confidence by learning from other women who have made the transition to motherhood rather than relying on a pre-set syllabus of midwife-led classes. It can help women to believe in themselves rather than relying on the professional to have the answers.

The community spirit which the midwives interviewed raised, and which can be successfully generated by bringing women together to share, would seem another way in which a belief in themselves can be facilitated.

Knowing What the Woman Wants

The midwives in the fourth interview focussed on the need to get to know women as an important part of being able to help them achieve their goals. Knowing what the woman wants, and believing that she can achieve it, helps the midwife to be able to practice in such a way as to make it happen.

4: "It takes sophisticated levels of communication to find out what women want and then to be able to advocate on their behalf."

These midwives, who were practising as caseload holders, felt that their ability to help the woman achieve her goals was enhanced through getting to know her well during the pregnancy. They were able to help the woman to make informed choice, to develop her confidence in herself and to believe that she was able to "do it".

This issue was also raised in the second interview with a lecturer who also carried a caseload. She highlighted the fact that continuity breeds confidence both for the midwives and the women.

2: "Having a relationship with the woman means that you know what the woman wants and you are committed to supporting it... it gives you the confidence to deal with the medical staff, to advocate when things go wrong or when the medics want to intervene."

The benefits already discussed in relation to continuity of carer in chapters three and six indicate that both women and midwives gain satisfaction in this pattern of care. The midwives interviewed initially supported the benefits to continuity and the opportunity to build a relationship with the woman. However, the way that an ongoing relationship can contribute to the midwife's confidence and commitment to helping the woman achieve her goal, to really believe that the woman can 'do it' because she is well known to the midwife, has not been described in the literature to my knowledge. This is an exciting extra dimension to caseload practice which may provide very positive benefits to women; it is worthy of further investigation.

The belief in women went hand in hand with the midwife believing in herself.

Believing in Yourself

<u>Politics</u>

A "political apprenticeship" as part of the learning to be a midwife was raised by the first midwife interviewed. She said that midwives need to develop a "belief that you can change things". In the apprenticeship model to learning, in her experience, there is a build up of confidence which comes from developmental stages.

1: "I watched it, I did it, I can do it!!"

This description would seem congruent with the apprenticeship model of learning described in chapter four. It seems in contrast to the learning realities, also described in that chapter, for many students of midwifery and nursing in the research studies presented, who did not generally feel positive about their learning experiences in practice. This quotation would seem supportive of the ideal of situated learning where learners are enthused with a passion for the occupation but, as pointed out previously, the current culture in the NHS may not support that level of positive enthusiasm on a regular basis.

The midwifery world this interviewee described was somewhat different to that in Britain as many of the midwives practising in Ontario had done so before legalisation of midwifery and "working extralegally takes strength". She had spent time in Britain and was aware of the system of care here and had opinions about the differences. Obviously her experience in Ontario was in a very different context; there are very few midwives in practice and they, necessarily, need to be very political in their approaches to meet the scrutiny and resistance from the established obstetric community. However the explicit development of political knowledge and skills in the student midwives in that context could be usefully considered in Britain to challenge the relatively apolitical stance of practising midwives here.

1: "There is a passivity in Britain... lots of things work in Britain because everyone knows their place and stays in it."

She talked about the midwifery preparation programme in Ontario and said that the students are explicitly taught how to be political, to understand the political system, to write up briefs, how to dress and talk confidently, to both understand and have the skills to bring about change. This knowledge and skill is used, both in helping to gain acceptance for the occupation as a whole, but also in working with doctors and nurses in the health service. The ability to debate and discuss evidence with confidence in order to help the woman have her choices respected was considered crucial and was also an important part of the preparation programmes.

1: "The students spend (their learning) years head butting with each other to become very analytic, not ruthless but with the ability to challenge."

All of these issues are important tools in helping midwives to learn to believe in themselves as well as the women for whom they are caring.

The second interviewee also raised the issue of knowing the evidence as an important part of gaining confidence.

2: "The ability to debate with medical staff and being aware of the evidence, therefore being on the same level academically (led to confidence)."

This confidence meant that midwives believed in themselves and felt equal to other colleagues.

2: "Feeling the equal to medical staff, not the junior ones who are not equal as they don't have the experience or depth of knowledge, but equal to the senior registrar or consultant."

The issue of the type of system in which midwifery operates was considered an important element in how confident midwives could feel about their roles. The "oppressive British class system" was raised in the group of three midwives from Australia and New Zealand who saw the new world as having a much more openness and "pioneering spirit". Similar to the Canadian experience, these midwives felt that with less devotion to hierarchy, there was easier collaboration and more willingness to

let go of control. It seemed they were describing a system in which midwives could more easily believe in the valuable role which they fulfil in supporting women.

In the second interview, it was suggested that the maternity services in Britain did little to help midwives develop a self-belief:

2: "The system stifles midwives, beats it out of them... midwives are always going on about what the protocol doesn't allow them to do. They can be completely bound by protocols, which stifles autonomy and innovation. Consultants writing protocols stifles autonomy."

The protocols themselves may be less important than the means by which they are developed. Consultant obstetricians still have considerable influence in the routine practice in maternity services; evidence based practice (as discussed in chapter three) may be overruled by the personal preference of the obstetricians. In some maternity units, protocols are developed collaboratively with members of the relevant professional groups making contributions. However, the current risk management culture (also discussed in chapter three) is leading to defensive practice which may constrain midwives in supporting the needs of individual women. Lack of confidence may lead to the midwife conforming to the protocol/ dictated practice in the unit even if it isn't what the woman actually wants. This midwife suggested that it was important to protect newly qualified midwives from losing the ideals they had developed during their training period:

2: "Trying to prevent newly qualified midwives from being sucked into the system; encouraging a support network for them so they can continue to remind themselves about what is important to them as midwives...The crucial days in forming autonomy in practice are the early days when newly qualified; maybe it's good to go straight into caseload practice with no additional experience while they are still thinking, forming ideas, the 'bedrock' of their practice."

The midwives in the fourth interview supported this idea of midwives going into caseload practice before becoming 'institutionalised' by hospital practice.

4: "The 'a- ha' that happens when a new midwife leaves the institution and starts to appreciate the benefits from caseload practice is refreshing. Newly trained midwives appear to adapt much more quickly - they had the experience in training and so have less trouble with the transition."

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The politics within the country, the maternity services and actual unit all impact on the way in which a midwife practises. They can foster a belief in the worth of the occupation or can strip midwives of confidence and control.

Kirkham (1999:732) describes the culture of midwifery in her report from a study undertaken to examine supervision of midwifery in England.

> The culture which emerged was one of service and sacrifice where midwives lacked the rights as women which they were required to offer to their clients, particularly around choice. There was a lack of mutual support and of positive role models of support with considerable pressure to conform. Guilt and self-blame were common as was learned helplessness and muting. This created many dilemmas to change especially in relationships. Change was either resisted, brought about by stealth or, less frequently, strategically planned.

This negative description of the current maternity services in England sets a context for the need for confident, politically astute midwives able to impact not only on the care for women but on their own self-perception. The disempowered position of midwives as (mainly) women in a large, hierarchical health service largely controlled by male approaches does not place them well to be able to support the needs of their clients. The opportunity to develop an understanding of power and control, of seeing that 'it can be done' with the right evidence as back up and to work in a community of practice which values their contribution, may help to prevent midwives being stifled by the system and foregoing their ideals for the norm.

Role Modelling

This issue came up in all of the interviews, as might be expected following the importance attached to it in the educational literature review. The importance of having midwives who demonstrate a belief in themselves in order to develop the approach in learners was considered paramount. The first interviewee talked about learning "confidence and competence" as well as the ability to project themselves positively. She suggested, it's important to

1: "Educate midwives to know it's down to them, what they do really matters and ultimately it's their responsibility.."

Role modelling by the leaders of midwifery was raised in the second interview:

2: "There is a need for strong midwifery leadership- the problem is often obstetricians are on the interview panel (for Heads of Midwifery positions) and they will be looking for someone who won't rock the boat and will be a 'nice little nursey'.

The interviewee went on to discuss how strong role models, especially in delivery suite, give midwives confidence as they feel they have a manager who would back them up. She gave an example of a phone call she had received when she was the supervisor on call. It came from a midwife on the delivery suite who was with a woman who wanted a water birth; the consultant on call wanted the woman to only use the water for pain relief not the birth. The midwife wanted to know if the interviewee would support her if she allowed the woman to stay in the water. Once provided with reassurance that the support was there, the midwife had the confidence to agree that the woman remain in the water.

There were specific elements of role modelling discussed in the third interview. Particular characteristics were described as desirable, including midwives who *"remove the need / desire to rescue and play God"* by avoiding unnecessary intervention, who have the confidence not to take over control from the woman and who are comfortable with uncertainty (as progress in labour and outcome of birth may be uncertain). This led to a discussion on peer support where midwives could learn confidence by expressing their uncertainty in groups when sharing decisions they had made in practice. This open scrutiny was felt an important way of developing confidence in midwives and could be achieved through effective role modelling by those with more experience.

The use of the peer group to share experiences and build confidence appears to provide benefits to midwives as well as to women. Cooke & Bewley (1995) discuss the value of group peer review as a means to improving and developing practice by making explicit the theory which underpins practice. This very particular type of group provides an opportunity for role modelling as midwives share ideas about how a scenario in practice could have been dealt with differently, benefiting from the collective wisdom of the group. It is a safe environment in which ideas can be tried out with peers in a supportive way.

The group in the fourth interview also talked about peer review as an important element of both support and learning. They undertake group practice meetings with peer review, where they talk through their practice decisions with colleagues; they identified how it takes confidence to 'take a risk', or try something new and different, in practice and then talk it through with peers. This 'risk' refers to a diversion from either the written or unwritten protocols of the unit; it implies personal or professional rather than clinical risk (the midwife stepping outside of agreed practice to support the needs of the woman). They felt that peer review had been a critical step to their self-belief, following the role model of the project leader in this undertaking when they first moved into caseload practice.

Refer not Defer

There was discussion about the collaborative nature of midwifery in the interviews, the fact that midwives need to work with colleagues from other professions, especially medicine. However, there was a distinctly confident way of engaging with doctors which had been lacking in the initial interviews; midwives were seen as needing to 'refer not defer' in cases of complication.

2: "The sign of a mature, autonomous midwife is the ability to recognise the need to refer, not giving up your role when you do so; asking for advice and asking them to do something that you know this woman needs (but is not in your scope of practice)- the ability to refer not defer."

This is a critical point; the self confident midwife is less defensive and is able to work collaboratively with other professionals rather than avoiding them or working alone inappropriately. Similarly, in the third interview there was a recognition that midwives are not islands unto themselves but need to work with others, being able to identify when the responsibility should be passed to another practitioner.

3: "Autonomy does not mean being independent, standing alone but should involve collaboration. Autonomy requires self awareness; it is an advanced skill; you must be aware of your own limitations."

Those in the fourth interview also highlighted ways in which referral could be undertaken without the midwife taking a figurative step down.

4: "The ability to collaborate not confront develops mutual respect - a two way process"

Indeed there was a confidence demonstrated in the ability to challenge the decisions made by medical colleagues (although this may be considered confrontational by some).

4: "I ask the doctor to 'justify their decision to me', it sets the right scene"

This confident approach to interprofessional working seems reflective of midwives who believe in the importance of their role without seeing it as an inferior one to medicine. The initial midwives had shared many experiences in which they had felt disempowered by medical colleagues who had taken over control of the labour / birth situation when consulted on an issue. They appeared to defer to medical opinion rather than meet the doctor as an equal; they seemed to lack the belief in themselves which was very obvious in the groups of autonomous midwives.

This self belief seems aligned to the psychological concept of the locus of control. Rotter (1966) undertook seminal work to develop this concept in order to explain differences in behaviour. He claimed that there are two basic types of individuals, those who believe that they have control over their lives, said to have an internal locus of control, or those who believe that external forces rule their destinies, said to have an external locus of control. Those with an internal locus tend to think they can shape their future by their own actions and they will grow to believe that such actions bring about reinforcements which they value most (Oliver 1993). In contrast, those with an external locus believe that fate will determine outcomes; this concept has implications for motivation, beliefs and behaviour (Oliver 1993). Hayes (2000) states that the belief people have over their degree of control in given situations can make a great deal of difference to their levels of stress. This can lead to becoming a self-fulfilling prophecy as 'internals' are more likely to make efforts to influence their lives with relatively little stress and 'externals' will take a more passive stance with higher levels of stress (Hayes 2000). Levenson (1973) claimed that parental influence plays a large part in the development of the locus of control, which suggests that it may be a learned pattern of behaviour.

Despite the initial wide acceptance of the construct of locus of control and subsequent rapid expansion of its use following initial publication, Rotter later raised some concerns about its misuse (Rotter 1975). He highlighted that it appeared to have been accepted as the major or central concept in social learning theory but confirmed his belief that it is not. The ability to predict behaviour is a complex interplay of variables (including expectancy, reinforcement and psychological situations); the locus of control construct may fail to provide accurate predictions as individuals will bring other things into play when they are making decisions about how to behave in a given situation. The positive value attributed to those with internal locus of control was also of concern to Rotter as he identifies that in different situations, there may be advantages to having either an internal or external locus.

Others have highlighted controversy over this concept; Adams & Bromley (1998) point out that the questionnaires designed to measure locus of control were not considered to have either face or construct validity. However, another theorist, Seligman (1992) defined a related concept which may add weight to the approach. 'Learned helplessness' was a concept developed as a result of animal studies. Seligman found that if animals were subjected to unpleasant experiences, over which they had no control, they tended not to take action in other situations in which the outcome was, in fact, under their influence. In other words, they lost the motivation to try and change things within their control as a result of repeated lack of success or negative reinforcement; the experience of being a victim and being helpless produces a kind of apathy (Hayes 2000). These individuals could be described, in Rotter's terms, as having an external locus of control.

Despite the controversy surrounding the locus of control concept, it appears to have been accepted fairly widely. Several studies were undertaken in relation to health behaviour in the past and an internal locus of control (i.e. those who feel in control of their destiny). Kerr (1986) found that those with internal locus of control engage in more adaptive responses when confronted with health problems; Phares (1976) found they were more likely to use contraception, Munro & Marston (1972) identified they were more likely to be near normal weight, James et al (1965) found more non

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smokers in this group and DeVellis et al (1980) identified that they were less likely to be compliant with medical advice, demonstrating a personal confidence.

More recently, research has been undertaken in relation to locus of control and the work experience. Erbin-Roesemann & Simms (1997) found that individuals who are internally oriented and proactive (i.e. with an internal locus of control) perceived their jobs to be more enriching and intrinsically motivating whereas reactive individuals (external locus of control) report lower levels of job satisfaction and higher levels of perceived powerlessness. Ponto (1999) undertook a study looking at the perceived satisfaction of 150 nursing students in the Faculty of Healthcare Sciences, Kingston University and St. George's Medical School, in relation to their locus of control over the three year period of the educational programme (50 in each year of the programme). Similar to the previous study discussed, those with an internal locus of control perceived greater satisfaction. However there was no difference noted in the locus of control in the three groups at any point in the programme, so the students did not move from external to internal locus of control over the time spent on the programme of education. Another study looked at the locus of control and job satisfaction in 261 qualified nurses in Texas (Campbell 2000) and also found greater job satisfaction in those nurses who were rated as having an internal locus of control. A German study (Schmitz, Neumann & Oppermann 2000) looked at burnout in 361 nurses in relation to locus of control and found that those with an external locus of control were more likely to experience stress and burnout in their roles.

These studies provide some evidence that a group who seem to feel in control of their lives are more likely to make decisions about their future in a positive way and experience more satisfaction in their work lives. The autonomous midwives interviewed could be considered as a group of individuals with internal locus of control. They would appear not to have learned helplessness, possibly suggesting that they had not had repeated negative experiences in which they were unable to exert control in the situation or that they had different earlier experiences which helped to build their confidence. This may be because they are different types of people in the first instance, those with different personalities from the midwives working in the local maternity service. It could also be because they had learned to believe that they could make a difference with and for women as a consequence of environment and positive

experiences while in their formative stages as student and newly qualified midwives. Both of these issues will be pursued in the rest of this research project.

Discussion

Believing is the core theme which has emerged from the analysis of these interviews. In contrast to many of the initial group interviewed, these were consistently confident midwives who felt able to help women achieve what they want from the birth experience. They did not appear to feel constrained by other health professionals nor the system / hierarchy unlike some of the initial group. It must be recognised that they had all chosen to be working in non hierarchical environments; possibly an internal locus of control had given them the confidence to move out of mainstream services. However they had all worked in conventional services at some point and had developed a strong belief because of or despite that experience. They believed in women's ability to birth and they believed in their ability to support women without unnecessary intervention. This has been learned, at least in part, from effective role models.

But it is not only from watching and emulating other midwives that this confidence is developed. Engaging in discussion with other midwives, opening oneself up to scrutiny by peers in a supportive group, knowing the evidence to be able to debate with colleagues with confidence were seen as important to continued development of practice. It was suggested that the system of care can have a negative impact on midwives; they may have their ideals and passions squashed by a maternity service which does not place the needs of women at the fore. Continuity of carer schemes helped to give some of the autonomous midwives the confidence to advocate on behalf of women, as they know what the woman wants having had the opportunity to develop a relationship through the pregnancy.

The literature provides some discussion / opinion about the importance of belief although I have not found any empirical evidence in relationship to the concept. El Halta (1998) says that belief and faith are two very strong universal forces; both can have a powerful influence on one's perception of birth. She suggests that an obstetrician is likely to want proof that a woman can give birth to a baby normally whereas a midwife would be looking for proof that the woman cannot, similar to the

discussion about medical versus social models of birth in chapter three. The distinction is subtle but the effect can be profound. The truth is that the midwife may only be in that philosophical frame of mind if she has been exposed to both positive experiences of birth and positive expectations by her role models.

Carla (1998), a direct entry midwifery student who found the initial part of her midwifery education programme (which was largely shared with nurses) to be a negative experience, questions whether a midwife with a nursing background can see beyond the 'sick role' and hospital protocols to become a truly facilitative practitioner. This background could make it very difficult for the student midwife to believe that women can do it without interference. This is reinforced by Ginesi (1996), a physiologist and NCT teacher, who claims that, despite the woman's body being exquisitely designed to have a baby, there seems to be a widespread lack of trust in that ability and a lack of real understanding of the normal processes of labour. Duffin (1996) suggests that the midwife is in the key position to strengthen a woman's belief in her own ability to give birth but this is only possible if midwives themselves believe that woman can birth normally.

The constraints which exists for both midwives and women at the time of childbirth are fundamental parts of contemporary Western culture. The male dominated, hierarchical system of health care (discussed in chapter two) in combination with the belief in technology and science as the answer to imperfections in nature (Davis-Floyd 1995) sets a scene in which it may be very difficult to believe. Midwives were trained in Britain in the 1970's and 1980's to accept medical intervention in labour and birth as a part of routine care; it became the exception rather than the rule that women escaped with no 'management' at all. Some of these midwives are now the senior midwives in the maternity services, often holding positions of leadership and in management, and may perpetuate a culture of control over women. They may have had limited opportunity to develop a strong belief in women's abilities to birth unassisted as, unless they have practised in the community and seen women coping in their own homes without the traps of modern medicine, they may have rarely seen the strength and beauty of natural birth. They may have no faith that birth can just happen.

With midwives lacking that belief acting as role models to students of midwifery, it is not surprising that the culture has not really changed. With little opportunity for midwives to develop relationships with women which last throughout the pregnancy and birth, they miss out on gaining the confidence that continuity brings. In cases where there really is a belief, midwives can be kept in their places by other midwives (horizontal violence), protocols or doctors if that belief leads to practice which is perceived to be out of the 'norm'.

Conclusion

These interviews have elicited a very different picture of midwifery practice from the initial ones. These midwives seemed to truly believe that they could consistently make a difference and did not feel that they were relinquishing control when inviting another professional in to care for a woman. Like the initial group, they were positive and enthusiastic about their chosen occupation but the negativity which was also present in the first interviews was not apparent in these. These midwives had chosen to step out of 'mainstream' practice; it could be argued that the environment in which they practice favours autonomy and does not place constraints on them so they are able to help women achieve their goals with no interference. However they seem able to choose to practice in this way rather than in the more traditional health services. This sets up the next question in this project - why have they chosen to practice outside of the usual system of care? Are they different kinds of people with different types of personality?

Chapter Eight
Personality Testing

Research Question Two - Why are some midwives able to practice 'autonomously' in a way which helps women to achieve the birth experience they want? Are they different types of people?

Introduction

As discussed in the introduction to this thesis, I was somewhat sceptical about the idea of trying to identify the personality traits of the two groups of midwives interviewed, to see if there appeared to be any significant differences. I knew little of the specifics of personality testing but was aware that there was a debate among psychologists about the validity of the construct itself as well as of the approaches to testing. The potential of being able to measure someone's personality appeared to me to be a very rigid view which lacked the subtlety normally associated with qualitative research. It felt like there could be a paradigm clash or challenge if I moved into quantitative data collection and analysis. However, as was pointed out in chapter five, both Glaser (1999) and Strauss (1987) encourage a wide interpretation of the term 'data collection' and Glaser (1999) supports the inclusion of quantitative data in grounded theory. In order to decide whether or not to proceed with this stage of the project, I sought advice from psychology colleagues and reviewed some of the literature on personality, traits and measurement.

This chapter starts with some of the results of that literature review to identify my justification for proceeding with this stage. Having been assured by both my psychology colleagues and the review of the literature that there appears to be at least some value in examining personality traits, I attempted to identify any major statistically significant differences between the two groups, recognising that the relatively small sample size might not elicit any. The purpose was merely to identify and take into consideration any major differences in the two groups rather than to make any attempt to define the particular personalities of the individuals interviewed. I will therefore present the findings from the personality questionnaires administered, relating them

back to the themes from the interviews and aiming to identify relevant issues relating to the development of the educational strategy.

What is Personality?

This discussion probably best starts with the question as to whether or not there is even such a thing as personality. The word personality is derived from the Latin 'persona' which refers to a mask used by actors in a play, suggesting that it is what is seen about the individual externally; it is the public face of the person (Schultz & Schultz 1994). B.F. Skinner (1953) argued that 'personality is at best superfluous and at worst a misleading concept', suggesting that personality is no more than a collection of behaviour patterns in response to one's environment. Despite this relatively early criticism of the concept, personality has become an accepted area of study within psychology although its profound complexity is recognised widely (Pervin 1990). Personality can be defined as

> ...that pattern of characteristic thoughts, feelings and behaviours that distinguishes one person from another and that persists over time and situations.
> Phares 1991:4

The key issues in this definition relate to the behaviours (and cognition and emotions underpinning them) to which Skinner referred but adds the notion of persistence. This is supported by Lanyon & Goodstein (1997) who, having reviewed a large number of definitions for the concept and identified a lack of consistency of opinion, put forward that "personality is an abstraction for those enduring characteristics of the person that are significant for his or her interpersonal behaviour" (p45). These two definitions have the issues of endurance and behaviour in common.

Allport's 1937 seminal text 'Personality: A Psychological Interpretation' articulated the objectives of a new movement which sought to define the psychology of personality as a field of study (Pervin 1990). His definition of personality is frequently quoted:

> Personality is the dynamic organisation within the individual of those psychophysical systems that determine his unique adjustments to his environment.
> Allport 1937:48

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This definition presents additional dimensions to the concept, the organisation of personality as part of a system, the integration of mind and body and the individual as adaptive. It would appear to complement the previous definitions in providing some relationship between the behaviour demonstrated in an individual with the whole person, linking the mental and physical, seeing the individual as active and growing in her / his environment.

This adds another issue to the discussion about personality, its relationship to both the environment and socialisation processes. The development of personality sits within the debate of 'nature versus nurture'. Pervin (1990) suggests that there has generally been a bias in psychology and personality theory toward an emphasis on environment, but that this has swung back and forth over the past four or five decades. He highlights that Eysenck in the 1950's called for greater attention to the issue of heredity; the environmental emphasis then returned for a period but nature reappeared as a key factor in the late 1980's. However the complexity of personality is now more recognised with the significance of both heredity and environment generally supported.

Behaviour (and therefore presumably personality) is a result of the complex inter-play of both genetic predisposition and environment but many still question which is the most significant aspect. Schultz & Schultz (1994) point out that many theorists assume that personality is shaped by both sets of forces, with some believing that inheritance is the dominant force and others claiming that environment is the strongest element. Plomin et al (1990) boldly conclude that approximately forty percent of the variation of personality is genetic as a result of reviewing the evidence from family, twin and adoption studies. Regardless of whether this specific estimation is accurate, these studies do show that both 'nature' and 'nurture' impact on the way in which an individual behaves. If Plomin et al (1990) are correct in their assertion that forty percent of personality is determined through genetics, that leaves sixty percent which is determined by other forces including life experiences.

Historically, personality and its testing has gone in and out of vogue in psychology although it was given relatively little attention for more than half of psychology's history as a science (Schultz & Schultz 1994). Freud's psychodynamic theory perhaps started the formal study of the concept of personality using his defined aspects of human

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functioning (id, ego and superego), consciousness, stages of development and early life experiences as the keys to understanding individual behaviour. Over time, many other psychologists have presented alternative theories to explain why people behave in different ways (for example, Pavlov's theory of classical conditioning, Carl Roger's phenomenological theory of self and person centredness, George Kelly's personal construct theory and Eysenck's three factor trait theory) (Pervin & John 1997). In the last century, the trait theory of personality gained popularity and it has been developed and refined to provide a mechanism for trying to define individual personality types.

Personality Traits

There has been a sympathy with many psychologists to the viewpoint that the basis for human personality is best understood in terms of basic characteristics or traits for more than the past century (Lanyon & Goodstein 1997). From the 1930's, psychologists began to try to determine how many basic traits there are, what they are called and how they can be measured. Two of the best known in the early field of trait definition are Eysenck and Cattell (Kline 1983). In the 1950's and 60's, personality traits were studied by these two and others as a means to identifying relatively stable characteristics in individuals. However the emergence of applied behavioural psychology in the late 1960's pushed trait theory out of vogue as the important emphasis in this school of thought is in relation to situations and environments as the significant determinants of behaviour. Mischel (1968) damned the trait theory by suggesting that people do not behave consistently regardless of the situation and that traits could not be successfully used to predict due to this inconsistency. By the 1980's, traits were gaining popularity once again; personality psychologists produced a new hierarchy of units of analysis (Buss & Cantor 1989) which were felt to be more sensitive mechanisms which included motives, values and personal goals as well as traits. This could have been merely a redefinition of the trait theory rather than an entirely new approach.

'Big Five' Factors

Thurstone's seminal research in 1934, involving sixty adjectives to describe personality traits, led to the belief that there are five common factors accounting for most of the intercorrelations identified (Lanyon & Goodstein 1997). Since that time, many other researchers have undertaken work to define the correct number of factors required to

describe and predict personality. There have been diverse findings along the way but the current most popular approach used for measuring personality goes back to five very similar factors as to those described by Thurstone and are known as the 'Big Five Inventory' (John 1990). McCrae & Costa (1987) confirmed the five 'robust' factors through objective tests, self ratings and observers' reports. Dimensions of personality are grouped under five main headings: agreeableness, conscientiousness, extraversion, openness and stability (although these may be termed somewhat differently by differing theorists). These factors are broken down into descriptors / items which also can be diversely described; those presented in a basic introductory psychology text are replicated here to provide a clear articulation of the type of characteristics which the Big Five attempts to measure as a starting point.

Big Five Factors

	Desirable	Undesirable
Extraversion	outgoing	introverted
	sociable	reserved
	assertive	passive
Agreeableness	kind	hostile
	trusting	selfish
	warm	cold
Conscientiousness	organised	careless
	thorough	unreliable
	tidy	sloppy
Emotional stability	calm	moody
	even-tempered	temperamental
	imperturbable	narrow
Openness to experience	imaginative	shallow
	intelligent	unsophisticated
	creative	imperceptive

Gross 2000

Although this description of the Big Five presents a fairly consensual presentation of the factors, different psychologists use differing terms to define traits. Criticisms of the

approach include the issue that "everyone has his or her own version of the Big Five" (John 1990:92). However, in his analysis of the main theorists' descriptors, John found sufficient conceptual similarities between the Big Five and other systems of personality description to feel confident of their contribution (John 1990). There is recognition that the Big Five dimensions represent a broad level in the hierarchy of personality descriptors and that five dimensions cannot possibly capture all the variance in human personality (John 1990). However they are considered "extremely useful for some initial rough distinctions, but of less value for predicting specific behaviours" (John 1990:93). John (1990) concludes, following his rigorous analysis of the Big Five Factor taxonomy, that its structure is a major step ahead in improving early factor systems, providing an "integrative descriptive model for personality research" (p96).

One of the claimed strengths of the Big Five Factor approach to personality trait identification is that it appears to provide relatively stable results throughout adulthood in contrast to those using different personality units, such as life tasks, personal strivings or the study of biographies (Hampson 1999). This author suggests that personality, as defined by the 'Big Five' trait scores, assessed across time points from three to thirty years apart remains reasonably consistent.

There has been other research undertaken to determine the consistency of personality as measured by traits throughout life spans. Caspi (2000) followed up children from the ages of three to twenty one years; the three year olds who were regarded as uncontrollable grew up to be impulsive, unreliable and antisocial. The children who were inhibited when young became depressed and unassertive adults with fewer sources of social support. These findings led Caspi to conclude that there is consistency in personality as children develop into adults. Roberts & Delvecchio (2000) support the increased consistency of personality in childhood and early adulthood whereas McCrae et al (2000) found that some specific traits were more fluid than others. They reported on a large multinational study (Great Britain, Germany, Spain, Turkey and the Czech Republic) looking at the changes of the Big Five factors between the ages of fourteen and thirty and conclude that neuroticism, extraversion and openness decreased over that period but agreeableness and conscientiousness increased. It would seem that there is a general consensus about the relative stability

of personality as defined by traits over time but that some dimensions may vary within the specific factors.

One further strength of the Big Five structure appears to be its reliability across cultures as well as time. John (1990) presents a review of studies which confirm the replicability of the Big Five clearly with Germanic languages. He also suggests that the evidence for its use in non-Western languages, although more sparse at this point, is also encouraging but points out that definitive conclusions may be premature.

Evidence in Terms of 'Big Five'

The existence of five consistent and relatively independent traits in personality is supported by extensive and rigorous research evidence, presented in three comprehensive reviews (Goldberg 1993, Wiggins & Pincus 1992, Digman 1990). This does not mean that there is consensus agreement about the value of the 'Big Five' approach, however. Hogan et al (1997) have pointed out that nearly all of the research on the Big Five Personality Traits has involved self reports or the reports of knowledgeable others rather than observational measures, leaving the effectiveness of the approach open to some debate. Block (1995) agrees that there are methodological limitations or uncertainties to the approach which are largely ignored by its proponents. Pervin & John (1997) support the notion that traits may be consistent over time but recognise that cross-situational stability is more problematic to ascertain.

> There is evidence both for some cross-situational consistency and for some cross-situational variability. To a certain extent people are the same regardless of context and to a certain extent they are also different depending on the context. Trait theorists are impressed with the former and use such evidence to support their position, whereas situationist theorists are impressed with the latter and use such evidence to support their position.
> Pervin & John 1007:290

The 'Big Five' have been used extensively as a tool in employee selection and several studies confirm its value in this sphere. Barrick & Mount (1991) produced a meta-analysis of 117 research studies which reported statistical relationships between measures of at least one of the 'Big Five' factors and actual job performance. Lanyon & Goodstein (1997) discuss the results of this meta analysis and identify the following:

* conscientiousness emerged as the most consistent predictor of job success among the five factors, regardless of the job

* extraversion was a valid predictor for two specific occupations: management and sales

* extraversion correlated well with success in training but less so for job proficiency

* openness (to experience) also correlated well with training proficiency but not for job proficiency

* (emotional) stability showed low correlation with any criteria

In another meta-analysis of 86 studies (Tett et al 1991), agreeableness was found to be the strongest predictor of job performance, followed by openness, stability, conscientiousness and extraversion. The results of these two meta-analyses demonstrate some differences in findings but both do show a use of the 'Big Five' approach for employers. In another particularly relevant study, Barrick & Mount (1993) explored traits in 146 civilian managers working in U.S. army installations. They found in the group as a whole that only conscientiousness and extraversion significantly correlated with job success. However when the study sample was divided into two groups, those who had a high level of autonomy in their role and those with relatively low levels, much more striking results were found. In the high autonomy group, those who scored highly on conscientiousness and extraversion were far more successful. In addition, agreeableness appeared as another predictor of success. The conclusion was that with the absence of close supervision at work, the manager's personal sense of responsibility and his / her approach to dealing with others became more important determinants of success.

The Tool Used in this Study

Although I wasn't particularly looking at job success in this study, as I was not suggesting that either group were more 'successful' in their employment than the other, the evidence in respect to use of the 'Big Five' seemed to indicate that these traits do identify characteristics of different groups. With the support and advice of a psychology colleague, I put together a questionnaire using fifty validated descriptive statements / items available on the 'Personality Project' Website from the 'International Personality Inventory Pool' (IPIP)(see appendix 5). This is a collaborative project through which items are developed in the public domain, equivalent to those from commercially

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published tests. Each factor (agreeableness, conscientiousness, openness, extraversion and stability) had five statements relating to it (for statements in each factor, see appendix 6). The questionnaire used a Likert scale, asking individuals to use the rating scale to describe how accurately each statement described them at present, not how they might wish to see themselves in the future. They were asked to be as honest as possible and were assured of confidentiality. The statements were either positive (e.g. 'Am the life of the party') or negative (e.g. 'Don't talk a lot') and were mixed in order to try to prevent the tendency for respondents to repeatedly use a similar rating. Eleven of the initial fourteen midwives and eight of the nine in the second group completed the questionnaire.

The tool is a self-reported inventory or a 'personality assessment technique in which subjects answer questions about their behaviours and feelings' (Schultz & Schultz 1994). The other techniques available to test personality include projective tests (e.g. ink blots, word association, sentence completion), clinical interviews, behavioural assessment and thought sampling (Schultz & Schultz 1994). All of these techniques would require a trained psychologist to administer and there is no more conclusive evidence that any are as or more effective as the Big Five inventory. On that basis, I proceeded with the questionnaire designed with my psychology colleague.

Sample

The personality tests were sent to all of the midwives interviewed in both groups. I marked the two sets so I could determine which replies came from which group but indicated in the explanatory letter sent with the questionnaires that I could assure them anonymity if they did not include any identifying feature in their replies. There was some difficulty tracing four of those in the initial group as they had moved from the maternity unit in the intervening period. I tried to contact them via the Trust's Human Resource Department unsuccessfully; the Department apparently did not have forwarding addresses. I then contacted a midwifery manager who was of some help and finally the link lecturer was able ask some midwives who were still in contact with some of them to forward the tests. For the second (autonomous) group, I posted questionnaires to those in this country and emailed them to those abroad. I recognised that anonymity could not be assured with those who emailed the questionnaires back to me but offered them the opportunity to return them by post, if they preferred. In total,

I received eleven of the fourteen questionnaires from the initial group and eight of the nine 'autonomous' midwives (one was travelling and, despite a number of requests / reminders did not manage to return the questionnaires). These were analysed using SPSS (Software Package for the Social Sciences).

Analysis

A database was generated on SPPS (Software Package for the Social Sciences); I entered the responses by hand on a paper copy initially. This allowed me the opportunity to inspect the data and consider how consistent the replies were within the factors. There were some outlyers, responses which seemed unusual or inconsistent within the factor, in some cases. Due to this finding and the small sample size, it was recommended by a statistician that non parametric testing be used to reduce the effect of distortion.

The data were then entered onto the electronic database so statistical analysis could take place. In order to determine whether the tool was valid for use in this study group, the next step was to undertake Cronbach's Alpha, a test which analyses the responses to questions within each factor. This identifies whether the level of consistency is sufficient to be valid. The findings indicated that the tool was valid in this study group.

Figure 1

Cronbach's Alpha Scale: Reliability Analysis

Purpose: To determine how valid this tool (Big Five Factors) is in this study group

Sample: Number of cases in total = 19

       Number of items for each factor = 10

Findings:

Agreeableness -	Alpha = .8213
Conscientiousness-	Alpha = .8430
Extraversion -	Alpha = .8646
Openness -	Alpha = .7098
Stability -	Alpha = .8491

Conclusion: The tool is valid to use with this study group.

The final step in the analysis was the Mann Whitney 2 tailed U test, which looked at the difference in the means for each factor between the two groups.

Findings

The findings are presented in two ways: significance values of the traits in the two groups (figure 2) with means, range and mean rank, and a bar chart of the means profile of the two groups (figure 3).

Figure 2

Factor	A	C	E	O	S
Mean (range)					
Group A	4.44(3.2–5.0)	3.97(2.5–5.0)	3.65(2.9-5.0)	3.62(3.1-4.3)	3.5 (1.6-4.5)
Group B	4.45 (3.5-5.0)	4.21 (3.6-5.0)	3.58(2.8-4.7)	4.1 (3.5-4.7)	3.67(2.8-4.2)
P value =	0.934	0.619	0.868	0.038	0.868

Mean rank					
Group A	9.91	9.45	10.18	7.73	9.82
Group B	10.13	10.75	9.75	13.13	10.25

A= agreeableness
C= conscientiousness
E= extraversion
O= openness
S= stability

Group A = initial interviewees
Group B = autonomous midwives

Figure 3

Comparison of means between groups

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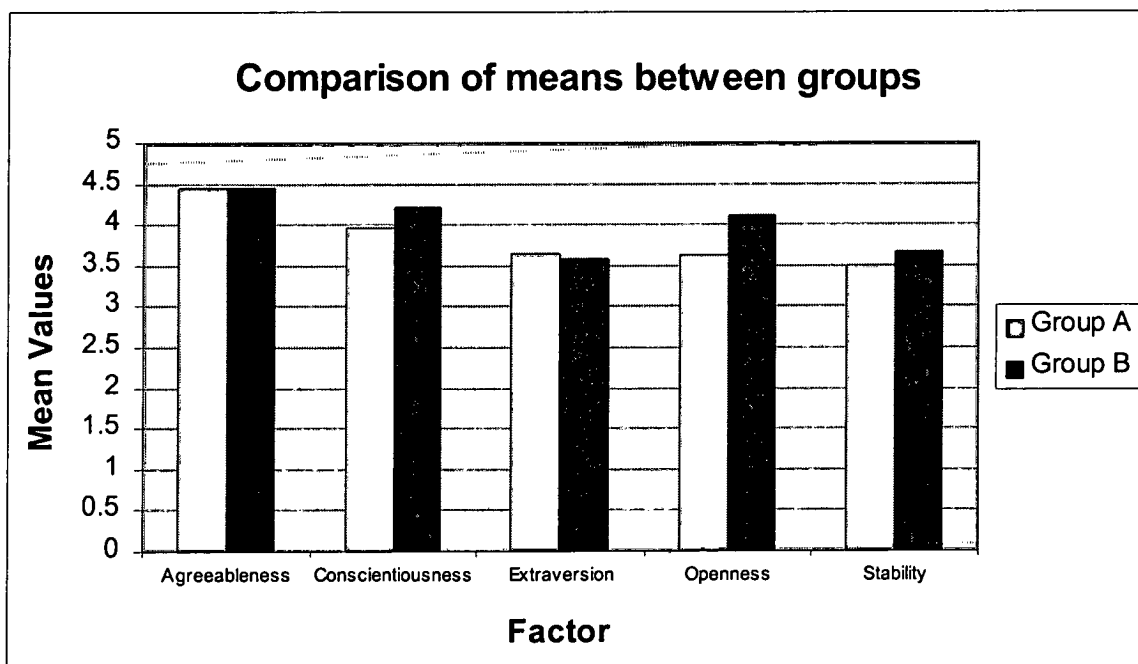
The only statistically significant finding of difference between the two groups based on this test is in openness to new experiences. In the first group, the mean is 3.62 and the mean rank is 7.73 with a range of 3.1 to 4.3. In the second group, the mean is 4.10 and the mean rank is 13.13 with a range of 3.5 to 4.7. The significance value is 0.038 (the p value is less than 0.05) for openness; no other factors proved to have a significant difference.

This finding may be somewhat difficult to interpret as the sample size is very small and the samples themselves are not random. This is part of a small qualitative study in which the sample was never intended to be truly representative (as discussed in chapter five); although the first group was a somewhat random selection of midwives from one fairly typical maternity unit, the second group was purposefully selected (as described in chapter seven). It could be argued that statistical testing is not useful in this context as these tests are intended to determine significance in large, random samples. However the purpose of considering both the whole issue of personality and in undertaking statistical testing was to contextualise the findings to date from the rest of the project. The intention was to question whether the differences between the two groups of midwives interviewed was merely a fixed or genetic one, which would go beyond the scope of an educational strategy to change. Despite the limitations acknowledged here, there can be some confidence that these groups are not completely different types of people; therefore there appears to be justification to move to the next phase of the study which will be to consider critical events in the lives of the second group of midwives.

Recognising the need for caution in extrapolating complete confidence in the findings, the implications of 'openness to new experiences' will be considered in relation to potential usefulness in the development of an educational strategy.

Discussion

The second group of midwives interviewed were found to be more open to new experiences than those in the first group. This would seem to be entirely in keeping with where they have positioned themselves in the midwifery world. Despite being of relatively similar age and length of experience to the first group, the members of the second one had stepped out of traditional, British style midwifery to fulfil a more

autonomous role. Their ability to believe in women may well have been developed as a result of being able to see things through 'fresh eyes', not accepting the norms they saw in practice as students and midwives working in a traditional service.

There would seem to be a number of issues to consider in respect of this finding: does being more open make one a 'better' midwife or just one who is more interested in new experiences?; does openness help you to believe more in women and birth?; can you foster openness in individuals and, if so, can this happen in an educational programme?

We all know people who use experiences in very different ways; as identified earlier, the experiences of the autonomous group seemed to lead them into an alternative form of practice. The way that midwives see their worlds, the 'lenses' through which they view practice, must filter experience in some way. The culture or environment clearly must be important to that filtering but individual personality may also play an important role. The environment in which the initial midwives practised is that of a bureaucracy, a large institution in which they are relatively small players. They appeared quite helpless in some situations; this helplessness may have been learned as a result of their position in the organisation. The fact that they had chosen to remain in that organisation may add weight to the idea that they are less open to new experiences than the autonomous midwives who had all moved into roles where they are less constrained by their environment.

The autonomous midwives may also be considered as having internal loci of control, as discussed in the previous chapter. Those with an internal locus feel more able to take control of their own destinies and feel that fate plays less of a part in life choices. Assuming that locus of control is a valid construct, the results of these personality tests would seem to corroborate that proviso. 'Openness to new experiences' and an internal locus of control would appear to have a distinct synergy.

As is accepted in the literature on the Big Five Factors, the descriptors are very broad terms which summarise a large number of distinct characteristics. It may be helpful to look specifically at the statements / items used to define openness, in the

questionnaire which the respondents completed, to understand more clearly the potential of these findings in an educational strategy.

The positive statements are:
    have a rich vocabulary
    have a vivid imagination
    have excellent ideas
    am quick to understand things
    spend time reflecting on things
    am full of ideas

The negative ones are:
    have difficulty in understanding ideas
    am not interested in abstract ideas
    do not have a good imagination
    use difficult words

In considering these in more depth, it may be more apparent how this finding can be useful in the educational strategy. Teaching and learning methods which encourage students to come up with new ideas and consider imaginative approaches to care (be creative), which enhance reflective skills and challenge students so they develop cognitive skills may all contribute to students who are open to new experiences. Learning experiences which help students to consider abstract notions, to analyse personal and professional philosophies and to critique the impact of these on childbearing women may be an important element in facilitating the growth of openness.

Conclusion

This stage of the research project has examined the personality traits, as defined by the Big Five Inventory, of the two groups of midwives interviewed as a control for any major difference. There is only one statistically significant difference between the two groups; the 'autonomous' midwives appeared to be more open to new experiences than the others. There may be some helpful pointers in the descriptors used to define this openness which can be used in the educational strategy. However, having found

that there is a limited difference in the two groups, the last question in the project emerges. As these two groups of midwives did not present as very different types, is there another reason for their differing experiences in practice? Are there any particular experiences, either professionally or personally, in the autonomous group which have helped them to become the type of midwives they are? If so, are any of these experiences replicable in an educational programme?

Chapter Nine

Critical Events: The Autonomous Midwives' Stories

<u>Research Question Three - Have there been any critical events in this second group which could be replicated in an educational programme?</u>

Introduction

This chapter presents the findings from the final stage of this project. Having examined the issue of personality and identified that there was only one significant difference in the personality traits in the two groups of midwives studied, that of openness, it seemed appropriate to look in more depth at experiences which may have been significant. I wanted to know whether anything had happened to the autonomous group which they felt had been instrumental in shaping them as midwives, as 'believers'.

Therefore I contacted the autonomous midwives once more and asked them to relate any critical events which had taken place in their personal or professional lives which they felt had impacted on the type of midwife they had become. I asked them to tell me any stories about their lives which might help me to understand how they had developed the confidence and belief which they had. My ideal would be to find some experiences which could be modelled in an educational programme.

Although I started my research project with interviews which encouraged the telling of stories, it was only when I had interviewed the second group of midwives that I realised that I may not have asked that group to tell me the most important stories. Once I realised that the second group had, generally, a different interpretation of midwifery, it was important to ask them to tell the story as to why they thought they were that type of midwife. As a number of the 'autonomous' midwives interviewed were not in the U.K., I asked them to either write or tape these stories to me so I could try to understand any key life events which had shaped their professional development.

Sample

Following the findings the personality tests, I asked the 'autonomous' midwives to write or tape record for me a narrative which would highlight any critical events in their lives (personal or working) which they believed had impacted on their development as

midwives. Two responded almost immediately with succinct written accounts by email of critical incidents in their lives. One chose to tape her story and gave me the tape to transcribe; this was a much longer account with many specific examples from her career. I did a telephone interview with another while she was visiting England (as she did not have enough time to meet me); the comprehensive notes from this were typed up and sent to her to ensure I had captured her words. Two others took up my offer to meet them again and interview them; these interviews were transcribed verbatim. Despite several attempts and reminders, I have been unable to elicit any data from the remaining three participants.

Analysis Approach

The data collected vary in length and in detail provided; this has set up some challenges for the analysis to ensure that all of the voices are heard. In order to ensure that the richness of the stories told has been sufficiently represented, it seemed important to look at these stories as wholes as well as considering the codes and categories therein. The approach used has been to code the transcripts initially and then to step back and consider the words used by the storytellers more globally so that the overall sense did not get lost in the detail.

Coffey & Atkinson (1996) describe an addition to the code-and-retrieve approach to grounded theory analysis with the use of narratives. They call this 'domain analysis' which involves close examination of the actors' use of language, seen through their choice of particular words, phrases and metaphors. The way that the language constructs meaning needs to be considered as well as the actual words themselves; Alvesson & Skoldberg (2000) support this by suggesting that narrative does not simply consist in adding episodes to one another but also constructs meaningful totalities out of scattered events. The need to grasp the macro along with the micro in this analysis was an important feature of this stage of the project. I read the transcripts / stories many times before starting to code so I did not lose the totality by focussing on the minutiae. The codes which emerged came from both processes and the integration of the notes I made through both stages of the analysis.

It is important to remember that most of these stories were spontaneous, in that there were no trigger questions other than the starting one. For those who provided the data

with no other contact from me following the initial request (three), their comments were structured by their own priorities and values. The other three (one telephone and two face-to-face interviews) had more interaction with me but, in reviewing the transcripts, my input was minimal. The follow up questions merely picked up on an occasional point for some additional clarification. The potential for the stories to be very diverse was clearly present as I was not trying to test out previous themes at this point. The sheet was blank for these midwives to fill in from scratch. However, themes emerged quite easily from the data; there were remarkably similar issues raised but in different ways with different styles. Possibly this isn't surprising as these midwives would have already undertaken some initial analysis themselves in determining what stories they would tell me.

Findings

Four broad themes emerged from the data relating to: the personal ideological stance of the participant, frustration with the status quo, role models and their belief in women. This is a relatively brief chapter as most of the findings relate back to other issues discussed previously in the thesis. They confirm findings from earlier stages of the project and provide a concise set of concepts on which to build an educational strategy.

Ideology

Four of the six midwives identified issues relating to the role of women and politics. Two suggested explicitly that an ideological / political view was an important part of their personal approach to practice.

1: "In my teens, I developed a strong socialist and feminist ideology that has remained with me all my adult life and even now influences the broader context of my practice."

4: "I found the woman's movement in the late 60's and early 70's...When I read Germaine Greer's 'The Female Eunuch' the lights went on.... I'm a P.K. (preacher's kid) and was brought up with Christian values and socialist values."

Two others raised issues about strong women as having an impact on their stance.

2: "I did a training course with a very radical group of women academics and learnt more about midwifery than I ever did in my hospital training programme.."

6: "It's often the case in a female profession- quite suppressed in a way. It's not the way I was brought up. The men in my family as well are always very respectful with women... I do come from quite strong women in my family, my mother is and my grandmother, have all got quite strong personalities and I have surrounded myself in my friends, I've got quite a group of strong female friends."

These comments reflect on the earlier interviews with this autonomous group where both feminism and politics emerged as concepts (see chapter seven). The most central and common belief shared by all feminists is that women are oppressed (Stanley & Wise 2002). This oppression is exemplified in the gendered nature of professions in general and of the position of midwifery in particular. Hunt & Symonds (1995:37) point out that the practice of midwifery, especially that which takes place in hospital in Britain, "fulfils the functions of a feminised semi-profession, bound and dominated by the masculinised profession of medicine". The discussion in chapter two on professions and professionalisation highlights the gendered nature of the construct and supports the relatively lowly position of midwifery as a semi-profession, consisting mainly of women.

However, the narratives from this group of midwives, who articulated either feminist values or a significant influence from strong women, did not feel oppressed to me. Supportive of one of the themes which emerged in the interviews undertaken with this group, that of 'refer not defer', their personal ideology appeared to contribute to their strength.

> The first psychological demand that flows from a woman's social role is that she must defer to others, follow their lead, articulate her needs only in relation to theirs. In essence, she is not to be the main actor in her own life. As a result of this social requirement, women come to believe they are not important in themselves for themselves. Women come to feel they are unworthy, undeserving and unentitled. Women are frequently self-deprecating and hesitant about their own initiatives. They feel reluctant to speak for themselves, to voice their own thoughts and ideas, to act on their own behalf. Being pushed to defer to others means that they come to undervalue and feel insecure about themselves, their wants and their opinions. A recognition of a woman's own needs can therefore be complicated and a process occurs in which women come to hide their desires from themselves.
> Eichenbaum & Orbach 1982:29

In contrast to this description, it would seem that the experiences that these autonomous midwives had along the way gave them the confidence to challenge that

oppression or need to defer, both for themselves and for the women in their care. Exposure to groups of radical female academics, strong women within one's own family or as friends, all contributed to their feminist consciousness. This has synergy with the New Zealand partnership approach to midwifery described in chapters three and six. The strength which women and midwives gain by working collaboratively together, each member of the partnership needing and valuing the other, can challenge oppression and change practice. The initial group of midwives interviewed did not articulate this mutual need and trust; their focus was on the woman needing and trusting the midwife rather than this being a two way scenario. The autonomous midwives exhibited a belief in women which supported mutual trust and a willingness to collaborate as equals.

Hunter (2002) identifies the way in which differing occupational identities and ideologies develop in response to social, economic and political events, in her study of 'emotion work' in midwifery. One description of occupational ideology is "the system of beliefs, ideas, language and attitudes that forms the distinctive perspective of an occupation and justifies its existence" (Langton 1991:150). Ideology and identity combine to form the basis of the perception of an occupation; what seems striking from my study is that these two groups of midwives seem to perceive their identities as quite different despite being part of the same occupational group. The findings from the personality tests demonstrate some difference in traits between the two groups which may partially explain this different perspective. However the 'social, economic and political events' raised above must also play a significant part if we are to support the contribution of both genetics and environment to personality discussed in the last chapter. An occupational ideology based on feminism (either formal or informal) seems to have helped shape an occupational identity for the autonomous midwives as 'believers'. This belief seemed to be largely missing in the initial midwives interviewed; they may not have had social or political experiences which helped them to develop belief as part of their identities.

The inclusion of political ideology by the autonomous midwives in their critical events provides significant support for the importance of a feminist perspective. A belief in women and social justice may underpin effective practice and help to give midwives confidence to support women's needs effectively, regardless of the environmental

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pressures. Linking this back to the partnership approach to practice, continued experiences in which midwives and women unite to challenge the status quo may provide an ongoing reinforcement of both the need to and potential of believing.

Frustration with the Status Quo

All of the midwives identified that things were not ideal in the maternity care system where they had originally practised and this had caused them to want to be able to do things differently. Two suggested that their own experience of giving birth had made a significant impact on wanting to be able to effectively support women as a midwife. This arose as a result of negative experiences for these two.

2: "Key events in my personal life were the births of my two children. The first a medicalised event and an induced labour of what turned out to be a premature baby (oops the scan was wrong).. until then I was an uncritical consumer of the maternity service..this was 1975. My son was born 4 years later and I tried to find someone to help me have a homebirth but to no avail but managed to find an obstetrician who was less medical than most... my daughter was able to come with us... the first sibling at a birth in the hospital... she came to antenatal classes with us too... my friend came to support her and take photos at the birth... also a first for the hospital... and I read Immaculate Deception and got ANGRY."

4: "I knew I wanted to be a midwife after the birth of my own children. The first was a hospital birth; I 'had to' (not given any option). The second was a home birth in defiance of the system."

Both of these midwives had experienced an unpleasant first birth in hospital which had made them search for an alternative for the second birth. Having had a much more positive experience the second time, this fired their enthusiasm for midwifery in order to be able to help other women achieve similar positive births. This, from personal experience, is a reasonably common reason for women to come into midwifery, especially onto the three year programme. Positive personal experiences of birth can enthuse women with the potential career options which midwifery offers. These students, by virtue of already being mothers, are normally mature and bring life experience with them. They often bring energy and passion; those who have had a positive experience probably also bring belief with them. I am not aware of any research on this phenomenon; it would be an interesting project to identify the career pathways of students who have come into midwifery for this reason to see where they end up practising.

The current culture of the maternity services, as described by Kirkham (1999) and referred to several times in this thesis, corroborates the view that women are not always supported in achieving their ideal birth experience. As highlighted in the example of active management of labour in chapter seven, the dominance over labour and birth by an interventionist approach, which aims to control nature, can lead to the frustration of women seeking a natural experience. The medicalisation of birth, based on the emergence of scientific western philosophy, with its reliance on technology as a means of control, is being rejected by some feminists who agree that this approach contributes to the erosion of women's roles in society (Sutton 1996). The personal experiences of these two midwives, in relation to their initial dissatisfying birth experiences, contributed to them seeking a different way of birthing for themselves and thereafter of supporting other women during labour and birth.

Other examples of frustration with the system included:

1: "My overall experience as a qualified nurse was that of frustration, and I felt disempowered by the strong medical model. I left to take up a career as a counsellor for people with alcohol problems. Later I worked again in the voluntary sector for a mental health charity. These experiences gave me insight into consumer advocacy. I chose to become a midwife through a desire to work with well women... I had several professional disputes with senior staff, which strengthened my resolve as an advocate for natural birth and for women's choice."

5: "That took me to community but what actually took me a step further was when I got to know women, throughout the pregnancy, I then found out that I was completely frustrated that I wasn't able to be there at the birth."

6: "For me personally, I think coming out of nursing, I wanted to get away from illness and that nursing world. I just felt 'If I could build a relationship with a woman rather than the traditional approach..' where it just felt so short-lived and it was just so fragmented. In that respect, that was the frustration really and I believed it would be great to be able to follow women up. I know you can make a difference for women."

The traditional approach to care in maternity services, therefore, appears to be leading to frustration both for women and for midwives who are seeking meaningful experiences. The issue of continuity of carer appears in these quotations as a means to increasing the satisfaction of the midwife rather than specifically that of the woman. It seems obvious that midwives who care will feel more satisfied if women are; this

'reciprocity' is raised by both Stevens (2002) and Fleming (1998) in their studies. It may also be that midwives who feel more satisfied are more able to care for and about women. Lack of opportunity for reciprocity may contribute to frustration; this frustration appears to have been a powerful motivator for these midwives to look for or create alternative models of care. The trait of 'openness to new experiences', found to be significant in the group of autonomous midwives on personality testing, may have contributed to their ability to step outside the norm and to try new, more satisfying approaches to practice as a response to such frustration. This will be an important issue to consider in the development of an educational strategy. The ability to cope with frustration in a given system, whether by developing coping strategies, by changing the system or by leaving it are all possible outcomes. The strategy will need to focus on positive mechanisms in order to improve care for women by developing midwives who seek change rather becoming apathetic or resigned to the status quo.

Experiences, both personal and professional, which lead to dissatisfaction can be powerful motivators for change. Although differing emotions were expressed by the midwives (anger, guilt, frustration), they all led to positive change. These midwives used their negative experiences to move to a new way of practising where they could really try to make a difference for women. Their openness to new experiences and possibly an internal locus of control, as suggested by the discussion in chapter seven and personality tests in chapter eight, may have helped them to be able to achieve this. It may have contributed to their abilities to use negative experiences in a positive way, being willing to try things differently to increase satisfaction. Opportunities to learn creative approaches and reflective skills (two of the criteria in respect to openness in the personality testing) may help to develop midwives able to consider the possibilities of doing things differently.

Role Models

All of the midwives talked about people who had made significant impacts on them, although one highlighted a negative rather than positive role model. These included

1: "As a student I was fortunate enough to work with some inspiring practitioners who treated women with respect and an immense kindness that I always try to emulate."

2: "The final event for me was setting up an independent midwifery practice with two great midwives who taught me most about being a midwife and trusting birth and women's ability to do it without unnecessary intervention."

3: "She was unkind to women and made comments about their relationships, particularly if they were black and their partner was white... I think it made me resolve never to be the kind of midwife that she was."

4: "My lifeline was joining the Association of Radical Midwives. I remember going into a midwife's sitting room and telling them that I had just started three year midwifery training and that it was awful, they opened their arms to me; ARM saved me."

5: "The vision, definitely. I think she also, there was never any hesitation about what midwifery care should be about. She could just always see where it should be... she certainly did influence me in a way."

6: "She was my community mentor when I was a senior student. She let me be independent as much as possible, she worked very like a consultant midwife in the community."

All of the midwives identified relationships with other midwives which had a significant impact on their development. Positive influences related to vision, inspiration, kindness, respect for women, trusting birth and caring. Negative ones included lack of respect and kindness for women. Midwife 3 was able to reject her negative role model; she also had positive ones who helped to demonstrate more positive approaches to care.

The issue of role models came up as significant in reviewing the literature on midwifery and nursing education. Working with mentors or other more experienced midwives who were positive role models in terms of their clinical skills, relationships with women and interactions with other professionals, all helped to make an impact on learners in practice in the studies reviewed in chapter three. The energy and passion for practice from these positive role models might make the community of practice more conducive to effective learning, as the situation in which practice is experienced is sufficiently positive to make students want to become a part.

Wickham (2002) exhorts midwives to treat students with the same sort of care and attention as they treat women, as students learn by example and role modelling.

If we want midwives to be open, kind and supportive of women and their choices, then we should espouse those qualities in our schools, facilitators and mentors. The role of facilitator of learning is very similar to that of midwife in the birth process. The kind of facilitator / midwife we choose to be will shape the hidden curriculum we pass on to aspiring midwives.

Wickham 2002:306

This is supported by the concept of 'situated learning' (Lave & Wenger 1991), as values which are demonstrated by those in the community of practice will shape learners in that environment. These autonomous midwives identified both positive and negative role models as key to their development, shaping the type of midwives they were to become.

Believing

Some specific words used in these stories helped to reinforce the theme of 'believing'. These midwives, once again, discussed experiences which had helped them to believe in women, birth and the midwife's ability to make a difference.

1: "I was fortunate to attend homebirth and was impressed by the strength and tranquillity of birth."

2: "Trusting birth and women's ability to do it without unnecessary intervention... just simple (so it seems to the untrained eye) but actually very astute / skilled support."

3: "I was her midwife three times, all at home, and it was certainly a wonderful learning experience and one which I still use in teaching with students. She always did exactly the same thing. She would be downstairs dancing and rocking to music when I arrived at her home. Then she would go upstairs to be on her own for a bit, then I and her husband would be called upstairs to be with her in the bath. Eventually she would get out, walk to her bedroom and erect the ironing board. She would lean on this for a bit and finally get down on her knees. At this point, I would put on gloves and wait for the vertex to appear. VE's were completely unnecessary, her progress was obvious by her body language, her position and her behaviour. Her third baby was born with her (the baby's) two sisters, sitting on my thighs as I crouched down behind her."

4: "Being a midwife was the embodiment of my values and politics and I knew I could make a difference."

6: " Once I got there (caseload practice), I developed within it. We always felt we had to make it work so we were quite determined. That's where the passion comes in- believing in it and wanting to make it work for the women."

These comments corroborate the key theme from this research, the need to believe. The experiences identified in these quotations are varied - home birth, seeing women succeed with no intervention, caseload practice - but all led to these midwives believing that women can birth without technology, obstetricians or interference. Bosanquet (2002) points out, in her analysis of midwifery training in hospital environments, that working in large bureaucracies creates 'good girls' who adopt the norms of the organisation in order to be accepted. This links back to the studies on midwifery and nursing education where coping strategies are implemented to 'fit in' (chapter four). All the while the community of practice in which student midwives learn is one of hierarchy and medical control, opportunities like those described by these autonomous midwives may be too rare to make a significant impact on the type of practice which is learned. The culture of practice will be assimilated and continued by students who lack opportunities to witness and participate in non-medicalised births. Bosanquet (2002:305) sets a challenge for midwives to "pull down the stones that make us docile" so we are able to truly be 'with women' in a stage in the history of midwifery when the passion and enthusiasm for supporting normal birth may be at an all time low.

As was demonstrated in chapter six, many of the midwives initially interviewed seemed to lack belief; in contrast, in chapter seven, the belief that the autonomous midwives had in themselves and in the women they cared for shone brightly. The opportunity to really make a difference in the lives of women and the belief that one is able to do that seems to be a crucial concept of the theory of midwifery.

Conclusion

These autonomous midwives identified some significant motivators which had contributed to their development as midwives. In the main, these stories confirmed the data collected in the previous phase of the study; there were no remarkably different issues raised in these accounts than in the interviews or personality tests done previously. However, the distinct addition that this chapter makes is in the focus on the processes which led to their development as autonomous practitioners. The issues raised in their stories included an ideological / political belief in women and women's rights, frustration with systems which did not meet the needs of women (or the midwife), strong role models who exhibited positive values and positive reinforcement /

belief in birth and midwifery. Although both groups interviewed expressed frustration in certain situations, there was a distinct difference in the response to that frustration by the autonomous midwives. This group appeared to be able to use negative experiences as a basis for positive change, being open to new experiences. Their formative experiences helped them to challenge their current positions and to situate themselves in an environment where they are able to practice true to their values. It will be important to consider the possibilities of integrating this experiential aspect into the planned learning by student midwives.

The final challenge of this project is to synthesise the findings of all four stages of the project into an educational strategy which will help students of midwifery to develop positive, woman centred values and who believe they are able to make a difference for women.

Chapter Ten
Towards an Educational Strategy

Introduction

This study has produced a very large amount of evidence which needs to be considered in the development of an educational strategy. From the literature, there is the historical development of midwifery, its past and current status and the impact of professionalisation. There are the findings following the review of contemporary issues in the midwifery literature, what concepts are considered important to those writing about midwifery today. The theories of learning and the results of the structured analysis of midwifery (and selected nursing) research on learning are to be considered. The empirical results of the four phases of this study also need to be incorporated; the findings from the initial individual interviews, those with the autonomous midwives, the personality tests and the critical events identified by the autonomous midwives.

This chapter will start by considering some possible options for how this evidence could be used to inform a positive way forward. Having justified a preferred option, it will progress by synthesising the evidence from this study; it will then move to defining strategy and identifying the possibilities of a strategic approach to education. Finally, it will integrate the issues raised throughout this project into an overall vision for midwifery education and propose some tactics which can be used strategically in planning programmes of preparation for midwives.

The Options

A number of possibilities exist as to how the findings of this study could be used to best advantage. The aim of this project was to determine an educational way forward, which would lead to more positive experiences for childbearing women. However, at every stage of this project, the impact of the maternity services sitting within the enormous bureaucracy of the National Health Service, has surfaced as a key constraint to autonomous midwifery practice and to positive outcomes for women. Therefore, it would seem that there are both organisational and educational options to consider.

Lipsky (1980) asserts that training alone will not change the conditions in the bureaucracy.

> Worker training is less important for practice than the nature of working conditions themselves. Without a supportive network of peer working relationships, training to improve service capacity of workers is likely to wash out under the pressure of the work context.
>
> Lipsky 1980:200

As Lipsky suggests, improving the service (or care delivery in the midwifery context) will only be possible with a combination of factors - the right working conditions, a supportive network of peers and training / education. Firstly, in respect of the working conditions, (I will discuss the second and third points later in this chapter), changing the way in which maternity services are organised, removing the hierarchical structures of the NHS, may have a significant impact on the opportunities for midwives to practice in a more woman-centred and less institution-centred manner. Lipsky continues by saying that "creating the opportunity for self-determination of small units provides a context for considerable learning and the potential for achieving more client-oriented practice" (Lipsky 1980:208). The development of birth centres, or small midwife-led units, is an approach which would appear to be reaping positive rewards for women who want to avoid intervention during labour and for midwives who want to provide the appropriate support to meet that outcome (for example, Brittain 2002, Gowers 2002). The self-determining nature of these units would seem to favour autonomous practice and provide work satisfaction for the midwives employed there. Similarly, caseload practice appears to reap similar rewards for both women and midwives, as has been discussed in chapters three and six. Increasing the prevalence of birth units and caseloading schemes, so they are an option for all women, may make a significant contribution to the service. Ensuring that all students get an opportunity to experience the practice, in either one or both, during their programme could make a significant contribution to the development of believers.

A further point raised by Lipsky (1980) relates to the involvement of the clients of the service as a mechanism to improving practice. The potential power which is derived from partnership between women and midwives has been demonstrated in both New Zealand and Canada and discussed in a number of places within this thesis. Women (both providers of and users of the service) as voters can influence policy makers if

sufficient numbers come together for the same cause. This was the case in the legalisation of midwifery in Ontario, as was confirmed by one of the autonomous midwives interviewed. It was also the case in the national recognition that midwifery is equivalent to general practice in New Zealand. There are lessons which can be learned from these international examples which could be implemented in Britain.

Both of these organisational options, out of many possibles, could offer important ways to improve support for women and opportunities for the development of more midwives who believe and are able to put their beliefs into practice. The implications of each are far reaching and would require significant resources. Rather than ignoring them for this reason, I acknowledge how very important the context of practice is for women and for students.

There are clearly already a significant number of midwives practising in Britain who believe in normal physiological birth and in themselves. It would be very difficult to quantify this, however, but my aim would be to increase that number to a critical mass through a strategic approach to pre registration education.

> If we must depend upon a core of street-level workers who will strive to maintain integrity in the exercise of discretion, we may well ask what can be done to support and enlarge this core? Where such a core does not presently exist, we may ask what can be done to bring it into being? What can be done to keep the new street-level bureaucrats flexible in their response to clients and zealous in their commitment to client rights while delivering public policy? While pursuing these objectives, what can be done to insure that the new street-level bureaucrats possess the skills to intervene with clients effectively? It is helpful to ask these questions in these ways because they direct attention to building on opportunities that currently exist. They guide analysis of possible direction of street-level reform without directly confronting the enormity of attempting to think through fundamental reforms for the totality of street-level bureaucracies.
>
> Lipsky 1980:204/5

These questions provide a helpful focus and an approach to change that is incremental rather than trying to tackle whole scale reform that is beyond the capacity of any individual. The culture of practice is crucial but culture can be changed from the bottom as well as the top. My intention, at the beginning of this project, was to develop an educational strategy which would impact on the development of woman-centred midwives, as this is my area of both expertise and potential influence. Therefore the

rest of this chapter will focus on using the evidence from this study to explore the possibilities within the programme of preparation of midwives for developing students who believe in normal physiological birth and in themselves, and have the skills to use that belief. I recognise that changes to the provision of care are also significant to ensure that these students / newly qualified midwives are able to practice in woman-centred ways but propose that education is one means to that end.

The Issues

This section reviews the main issues which arose during the various stages of this project. It will highlight the significant evidence determined through both the literature reviews and research conducted in this study. These will be important in determining the key components of an educational strategy, which is based on evidence, and which enables students of midwifery to develop woman centred values and skills.

The History of Midwifery

Midwifery is one of the oldest recorded occupations in the world but its history over the past centuries in the West has been one of changing status and power. The pre-industrial midwife had status in the community and relative control over her practice. However since that time, childbirth (and therefore midwifery) has moved increasingly from a domestic to a public event, largely from within the home to the more public environment of hospitals. The participation of 'man midwives' in birth, which became increasingly frequent and significant between 1660 and 1770 (Wilson 1995), enhanced the technological interventions available to support complicated birth but also opened the door for medical control of normal childbirth. The regulation of midwifery in Britain in the early twentieth century set a course for its perpetuation but with a loss of self determination, controlled by a series of bodies which, until relatively recently, were dominated by medical practitioners. More recently, its alignment with the nursing structures in the NHS has set challenges for recognition of its unique contribution to the well being of women and babies. The medicalisation of birth, with ever increasing technology taking precedence over traditional skills, has led to a reliance on medical opinion and often intervention.

The professionalisation of the occupation, as a means to maintaining some status and power, has put midwifery in a position which is not always woman-centred. The

negative effects of professionalisation (defining individuals as needy, reliance on experts to deal with the need) have led to power differentials which, at times, are used to control the outcome for women. The struggle for autonomy and perceived status by midwives has also led, at times, to horizontal violence in the form of bullying both of women and of less experienced midwifery colleagues. The relative power midwives have over women may be overshadowed by their perceived lack of authority working in a large bureaucracy. They may feel powerless and lack the self confidence required to change things for the benefit of women.

The Midwifery Literature

The role of theory is to support and to make explicit the conceptual underpinnings of practice. Theory of and in midwifery goes largely unarticulated; some examples of midwifery physiological knowledge have been discussed but there is a need for substantial work by midwifery researchers to make explicit the embedded knowledge of practitioners. Without this, the assumption of obstetric / medical knowledge as the only authoritative knowledge will go unchallenged.

Technological approaches to medicine and maternity care have had two main effects. Increasingly childbirth has been seen as a medical rather than social event in the life of a woman and her family; medicalisation has led to a redefinition of the transition to motherhood as something which needs to be managed medically to be successful. It has also led to a lack of confidence in nature in childbirth and therefore in midwifery practice as a means to enabling 'normal' labour and birth.

Evidence based practice uses knowledge which has been 'scientifically' tested / researched as the basis of effective care for women and babies. However a relatively minor percentage of interventions have in fact been researched, leaving a significant majority based more on tradition than on formal evidence. The status of different types of research, with the randomised controlled trial being considered the gold standard in medical circles, is also a significant factor. This positivist approach to research prioritises external, controllable interventions as forms of treatment. Satisfaction in the individual woman's experience and situation is largely seen as secondary in this type of research, limiting the concept of 'evidence' significantly.

The reliance on statistical evidence to inform practice is part of a larger change in society whereby risk has increasingly become a motivating force. This change has led to a rise in the importance of the concept of risk in maternity care, the potential of complication rather than the diagnosis of it. This has blurred the lines of responsibility between those responsible for complications (doctors) and those responsible for normality (midwives) in childbirth and shifts the definition of 'normality' so that it is, effectively, narrowed.

In contrast to this, contemporary writers in midwifery continue to have a significant focus on the interpersonal or social aspects of practice. The need to be able to create positive relationships with women (with or without a system of continuity), use effective communication skills and support women in making informed choices are considered priorities by many researchers and authors. There is increasing evidence available to inform practice from midwifery researchers considering the social and emotional aspects of childbirth. However the impact of this form of evidence is largely overshadowed by positivist evidence in a risk aware and managed culture.

Educational Literature

The expectations of the outcome of programmes of midwifery education are laid down by both British and European directives / guidance. These sources highlight the key content of curricula but not the process by which they are achieved. Currently in the U.K., student midwives learn in two environments, the university and the practice environment. Integration of the learning in these two spheres can present challenges. I have focussed on three key educational approaches / philosophies which have a significant impact on the education of midwives; those of adult learning, situated learning and social constructivism. Adults bring life experience to their studies, they benefit from active engagement with their learning and value interaction with their teachers in a non-hierarchical manner. The principles of adult learning seem to currently underpin many programmes of midwifery education, as discovered in Fraser et al's (1997) work where interactive teaching methods were found to be prevalent in the study sites.

Situated learning, in contrast, is based on learning which happens as a result of practising in a particular situation. Learners adopt the approaches of those with whom

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they work in a 'community of practice'; teaching is not a formal process. Indeed, as discussed in chapter four, Wenger (1998:25) claims that education "cannot be a closed system that shelters a well-engineered but self contained learning process. On the contrary, it must aim to offer dense connections to communities outside its setting". This is very much in keeping with the practice experience which students of midwifery gain in maternity services, outside of the formal classroom experience.

Despite 'situated learning' being recognised by some as a valuable approach, students currently appear to expect to be actively taught while in practice and experience frustration when this is not the case. The predominance of research undertaken on midwifery education highlights the perception of continued gaps in effective support for learning in practice. In 'learning the trade', role models have a key role to play; however, there are inconsistent examples for students to follow, some providing positive examples but some demonstrating lack of sensitivity and caring. Students need to develop strategies for learning while they are in practice as direct teaching is limited in many cases. Students also develop strategies for coping with the stress of practice and for 'fitting in' to the prevailing culture. In 'learning to behave', the socialisation process often sets priorities around completing the work rather than meeting the needs of the women; students may adopt this set of values as it is the path of least resistance.

This socialisation relates to the social constructivist theory of learning, whereby individuals construct meaning from their learning experiences based on their past experiences and personal values. Enquiry / problem based learning is a constructivist approach to learning and teaching which bases learning on real life scenarios from practice so students learn in a context. There is some research on the effectiveness of this approach in other disciplines (e.g. medicine, nursing, therapies) but the evidence from midwifery education remains limited. Its impact on the socialisation process is not clear although there may be a potential for students who learn in this way to challenge prevailing norms as they are equipped with transferable skills. These skills include learning to learn skills, basing practice on evidence, communication and presentation skills, the ability to work effectively in a group and to facilitate the experience of others (rather than take control).

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The Study

The four parts of this study corroborate some of the findings from the literature reviews but also identify some unique perspectives.

<u>Phase One</u>

The findings from the initial interviews with midwives highlight the positive rewards for midwives when they are able to 'make a difference' with and for women. As identified in the review of contemporary midwifery literature, continuity, relationships and communication all form important ways in which positive connections between midwives and women are created. The midwives interviewed expressed satisfaction in cases where there was no interference by other health professionals and seemed to derive pleasure from 'special' labour and birth experiences when the midwife and woman really connected (for example, as described by the midwife who danced all night with the woman in labour to the music of Alanis Morisette). They valued being trusted by the woman in their care but expressed little about the need for midwives to trust women. Reciprocity appeared to be somewhat lacking; the potential for the strength derived from a partnership between midwives and women appeared unrecognised or unarticulated.

These midwives felt that preparing women was an important part of their role but this was one which was inconsistently fulfilled. They suggested that women did not always seem to have realistic expectations of labour, birth or motherhood; this in turn suggests a lack of effective preparation. Rather than trying to support women's wishes when they may not fit the norm of practice in a large bureaucracy, these midwives worked at trying to modify the women's expectations to reduce disharmony and frustration for both themselves and the women.

The midwives interviewed also expressed a belief that they need to 'make sure' that everything went well for the woman. There was minimal evidence that this somewhat idealistic expectation was consistently met. The midwives gave many examples of times when control was removed from them by medical or midwifery colleagues, leading to feelings of inadequacy and failure, and interrupting the positive relationship they had established with women. The historical review of midwifery and its current position within the NHS hierarchy corroborates these experiences. The midwives

interviewed felt they weren't able to 'make sure' and felt guilty that they had let the woman (and probably themselves) down in these cases. Despite some participants recognising that they should not be trying to 'play God', many appeared to be trying to do just that without using the tools of evidence-based practice and woman-centred care to achieve it. The potential opportunity to change practice, which could be derived from partnership with women, was not articulated by this group. They seemed to lack belief in themselves, in women and in physiological birth.

Phase Two

The 'autonomous' midwives interviewed portrayed a strong, positive image of midwifery. They appeared to believe in women's ability to birth naturally and in the midwife's ability to help make that happen. They had developed a political acuity and learned from positive role models; they had skills with which they could negotiate the desirable outcome for the woman. They displayed confidence and felt no need to defer when complication arose but were able to refer to the appropriate colleague with no loss of status or self esteem.

Community spirit was considered important; the midwife was described as a catalyst in bringing women together rather than acting as an authority. This partnership model is reflective of that in New Zealand where midwifery is now considered as having equal status to general medical practice. The advantage of midwives believing in that potential could reap benefits for midwives but, more importantly, for women having babies.

Phase Three

The personality tests, recognising both their limitations within such a small sample and the relatively contentious perspective of personality as defined through traits, demonstrated one statistical difference in the personality traits in the two groups interviewed. The 'autonomous' midwives were more likely to be open to new experiences than the initial group interviewed. These findings helped to support the fact that the two groups were not very different types of people other than in that one construct. However, this 'openness to new experiences' may provide some understanding as to why they had all sought to move outside of the traditional systems

of maternity care. The descriptors within the trait may provide some important directions for learning (for example, creativity and reflection).

<u>Phase Four</u>

Finally, the critical events described by the 'autonomous' midwives reinforced the findings from the interviews with that group. Critical issues in their development as midwives were identified as their personal ideological / political stance, frustration with the status quo in systems which did not meet the needs of women, and strong role models who believed in women and midwifery.

A different occupational identity was projected by these midwives; they had learned to believe in women and in midwifery through their experiences. Experience of caseload practice, home birth and seeing women birth without interference or external control had all helped to shape their belief systems. This highlights the need for a positive community of practice in which students can learn these positive values with enthusiastic and passionate mentors to support their learning.

Integration of Findings

Several of the issues just highlighted come together as key principles which could usefully underpin educational programmes. The main theme which I have identified in this project is the need to develop midwives who 'believe'. This word comes from both sets of interviews; one of the midwives in the initial group gave an example of a woman needing a forceps delivery and identified that her lack of belief may have contributed:

"maybe I should have got myself more together and believed that she really could have done it"

In contrast, some of the autonomous midwives explicitly said how important it is to believe in women:

"Believing in women rather than in us or anyone else...."

"all these (interferences) undermine the woman's own capacity, her belief in herself"

In this context, belief does not refer to faith of a religious type or to evangelism but to confidence in natural physiological processes and in oneself. It seems an appropriate word to capture the energy and enthusiasm which underpins woman-centred midwifery practice. Several guiding principles, derived from the study, can be articulated as the underpinning for pre registration midwifery programmes to help meet this aim.

History and Politics

The understanding of the history of midwifery can lead to insight into the current politics of the maternity services; the autonomous midwives have articulated the importance of political acuity and understanding of power differences in order to support women effectively. Students could benefit from exploring the concepts of power and control in order to avoid the unrealistic expectation that they can 'make sure', as described by the initial midwives interviewed. This perspective can lead to an inappropriate burden of responsibility; despite the progress of knowledge and technology over time, not everything is controllable (nor many would argue is that control desirable). There remain gaps in our understanding of many events, for example why some babies die despite all appearing normal. Students will need the skills in practice to help keep birth normal, to support the woman's wishes as much as is possible, but realistic understanding of the limitations of current knowledge may help reduce the feelings of guilt articulated by some of the initial group. Through the development of confidence and competence, students should learn to advocate, mediate and empower women. However, they need to recognise the limitations of their practice, be able to refer to colleagues as equals without deferring or losing status or self esteem, as discussed by the autonomous midwives. Skills in communicating confidently, working effectively with a range of people and presenting oneself assertively in an interprofessional context are key in this area.

Evidence for Practice

Using evidence to inform practice can be an important tool to challenge unnecessary intervention; this seemed largely under utilised by the initial midwives interviewed. However there is also a need to consider evidence diversely; the emphasis on positivist research in the medical community may overshadow the qualitative domain and the satisfaction / experiences of women. A balanced approach to the use of

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evidence, to include research from both paradigms, the woman's wishes, findings from the clinical examination and experience as valuable sources, should be fostered. The development of critical skills in assessing the value of a wide variety of sources of evidence as well as the skills to use this evidence, as highlighted by some of the autonomous midwives interviewed, is important. These include communication, learning to learn, critical, reflective, negotiation and interpersonal skills. Teaching and learning methods, for example social constructivist ones like enquiry based learning, can help in the development of some very pertinent and important skills.

Midwifery Theory

The relative lack of explicit midwifery theory remains a concern, as without articulated and researched alternatives to the current accepted authoritative source of knowledge, midwives are less able to challenge unnecessary intervention and clinical management approaches. However, the physiological knowledge which midwives are starting to articulate (e.g. the purple line, behaviour changes in labour) at this point appear as individual insights without a framework in which to fit them. The 'tricks of the trade', which midwives in the Association of Radical Midwives and those involved with the American 'Midwifery Today' conferences, share within the midwifery community may be helpful if midwives work in environments where they are able to practise them. In interventionist maternity services, midwives may not be able to learn about their effectiveness as alternatives to obstetric management sufficiently to challenge received opinion. Developing creativity and reflective skills in students and qualified midwives may provide an important means to tapping into embedded knowledge in future. Alongside this, there is a need for ongoing research into largely unexplored areas of midwifery knowledge in order to provide an integrated framework of midwifery physiological knowledge.

Role Modelling

Role models have come up as key through different stages of this project; the autonomous midwives interviewed talked about the importance of positive role models and this is corroborated by the research in both midwifery and nursing education. Seeing midwives effectively provide the support for women to help them birth without intervention is a powerful source of developing belief; as one of the autonomous midwives said *"I watched it, I did it, I can do it!!"*. Experience with positive role models

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may also help to shape a different occupational identity from the prevailing norm, one more aligned to the autonomous midwives rather than the initial group interviewed. Believing in women can be reinforced with a feminist stance; role models who demonstrate their belief in practice are likely to have a significant impact on the student's system of belief or ideology.

Situated Learning

The situation of learning is also key in the development of students who believe both in women and themselves. Positive reinforcement through repeatedly seeing women birth without interference is a powerful means; this is rarely the norm in maternity services where intervention is increasingly prevalent. Students who are socialised into a medicalised culture of birth may find it very difficult to develop a belief, as appeared to be the case in the initial group interviewed. Students will benefit from gaining experience in alternative environments and / or with exceptional role models if they are to develop the skills of supporting normal labour and birth effectively. Peer review is another skill which may be key to gaining confidence in working, as a member of both midwifery and interprofessional teams, and which can be learned in an open and supportive environment (indeed peer review itself helps to foster just such an environment). Many of the autonomous midwives pointed out how confidence grew through exposing one's decisions to peers, learning to offer and receive constructive criticism. This could be an important means to building confidence in students which they are then able to use in support of women.

Community

The concept of community spirit, as partnership both with women and with colleagues, is a final important principle. As highlighted, partnership with women is a potential source of power to change maternity services which is currently largely unexploited in Britain. One, in particular, of the autonomous midwives interviewed, expressed the importance of midwives being a catalyst for bringing women together. This helps to encourage relationships in which there is no dependence on the professional but recognition that life and mothering experience have a valuable role to play in support of peers. The literature on feminism supports the significance of the power of groups, as strength in numbers can be important in giving women the confidence to challenge situations of oppression. Students would benefit from developing alliances with

women, not just on a personal level but also by becoming aware of and involved in the wide range of user organisations in the U.K. They would benefit from learning how to function effectively as a member of a group in order to contribute to this important agenda.

To recap, the principles identified from the evidence in this project are that programmes of midwifery education should:

- develop politically aware midwives with an understanding of power issues and realistic expectations of their capabilities
- prepare midwives able to refer to colleagues without losing status or self esteem
- ensure student midwives develop the belief and skills to effectively support normal physiological birth whenever possible
- develop the skills of using a wide variety of sources of evidence in order to support decision making and advocate on behalf of women
- promote skills of communication, learning to learn, critical analysis, reflection, negotiation, group working and peer review
- enhance the creative and reflective abilities of participants
- provide positive role models in a conducive community of practice
- promote partnership working with women on both individual and group levels

Although these principles in themselves will not change the bureaucracy of care, they will help students to gain skills for coping within that environment and will be important in the development of an educational strategy. In preparation for that, the next section will discuss the concept of strategy, its role, potential and significance in the development of effective educational programmes.

What is Strategy?

The word strategy has its roots in the language of war. Strategy comes from the world of the military general and refers to the approach required to succeed at a campaign; it is the management of armies, troops, ships and aircraft in order to conquer the enemy (Concise Oxford Dictionary 1976). The strategy is the overall vision and overarching plan; the way in which it is achieved is referred to as the tactics of war. Mintzberg

(1991) identifies five different parts to the meaning of the word strategy which provide a complete picture of its differing dimensions:

plan: the consciously intended course of action

ploy: a specific manoeuvre or device to outwit an opponent

pattern: consistency of behaviour, either intentional or not

position: location / match of the organisation in an environment

perspective: the collective thoughts of those in an organisation which shapes intentions, perceptions and actions

These meanings clarify elements within strategy which will impact on its development and deployment. The values of the characters, their style, the political environment and the specific approach (or tactics) will all influence the way in which strategy is employed.

Strategy, by implication, relates to change. A strategic vision is articulated and a plan of tactics is developed to move the relevant players or organisation towards the goal. In respect of this project and midwifery education, the key theme identified as a result of the data collection and analysis is the need to develop midwives who believe and are skilled at functioning within a bureaucratic organisation. Therefore the vision in the strategy will be to create an environment in which students learn woman-centred values and to believe in their own abilities to support women in achieving normal physiological birth. This vision will require a plan which is based on a clear understanding of the current context of midwifery practice (position), the collective way of thinking in midwives (perspective), anticipated behaviours (pattern) and will need specific manoeuvres to achieve success (ploy). On the basis of the evidence gathered in this study, substantial change may need to be effected in both the university and practice experiences from which students learn to meet this vision.

Mintzberg (1991) aligns strategy to ways of 'seeing', as vision is considered key to strategic developments. He encourages strategists to 'see' in a number of other directions in addition to the obvious direction, ahead. 'Seeing behind' is considered important as any good vision needs to be rooted in an understanding of the past. 'Seeing above' in order to determine the big picture needs to be complemented with 'seeing down' so that the reality on the ground can also be considered. 'Seeing below'

entails scratching under the surface, looking for answers within the organisation. 'Seeing beside' refers to creativity (or lateral thinking) whereas 'seeing beyond' constructs the future, inventing a world beyond the one ahead. The final way of seeing, according to Mintzberg, is that of 'seeing it through' as strategy will be redundant if it does not bring about change.

These ways of 'seeing' are helpful in considering the development of an educational strategy. This thesis has 'seen' midwifery from many of Mintzberg's perspectives; I have 'seen behind' by reviewing the history of midwifery, 'seen above' by articulating current key concepts in the midwifery literature, 'seen down' by interviewing midwives about their practice, 'seen below' by comparing and learning more about two very different groups of midwives and 'seen beside' by considering alternative, creative approaches to learning. This final chapter will set out possible ways to 'see beyond', identifying a plan for educationalists to be able to implement and 'see it through'.

The Importance of Educational Strategy

The purpose of a strategic approach to educational development will be to identify a vision and core values which can be shared across programmes and settings so that all students of midwifery can benefit from a common understanding. As discussed in chapter four, there are agreed and defined expectations of midwifery education programmes set by the European Community and the United Kingdom Central Council (now Nursing and Midwifery Council). However, these expectations relate to content and do not set out either an ultimate vision nor processes for achieving the goal. This guidance is helpful but not really sufficiently robust to ensure students of midwifery adopt woman-centred values and acquire skills in supporting non-medicalised childbirth. An educational strategy underpins the development of a toolkit whereby curriculum developers are able to consider a variety of means to achieving the end. That end is a consensus vision for midwifery practice.

An educational strategy can create the right conditions for success, enabling the goal to be achieved but not necessarily controlling the detail of the processes or approaches. From my personal perspective, the strategy should define the ultimate vision and end product of a programme of education sufficiently clearly to guide the learning processes within. As raised earlier, the curriculum goal and approach should

help to remove the serendipity I experienced in learning woman-centred values, only once qualified as a midwife, by implementing relevant strategies in the pre-registration learning process.

It is important to recognise the totality of the curriculum in developing a strategic approach. As fifty percent of midwifery education programmes take place in practice, the cultures which influence both the educational institution's and the maternity unit's 'communities of practice' must be considered in a strategic approach to learning. This presents an enormous but not impossible challenge.

The Curriculum

A curriculum encompasses the whole student learning experience on a programme of education. In the case of midwifery education this includes both the time spent in the university / classroom and the time in practice, as described in chapter four. The component parts of a curriculum include the philosophy of the programme, the teaching, learning and assessment strategies, the indicative content, the student support mechanisms and the learning resources. In addition, there is a 'hidden curriculum' (Jarvis 1985) where the implicit values will be seated. In order to achieve the desired outcome of such a programme, ideally all of these component parts should be trying to achieve the same aim or vision of midwifery.

The evidence presented in the review of the stages of this project suggests that the main aim of the curriculum for preparation of a midwife would be to create a 'believer', someone who uses all of their knowledge and skills to help women achieve their desired outcome regardless of the environment. If the curriculum is considered as a pathway, while on the journey the student midwife would move from her / his individual starting place, with many possible values, to a consensus position on qualification where she / he has the confidence and competence to achieve this.

Implications

The ideal described above needs to be situated in the real worlds of both higher education and midwifery practice. The most effective way of creating a midwife who 'believes' would seem to be to offer them opportunities to learn the occupation surrounded by others of similar values, both in the classroom and in practice. However

the culture of midwifery in Britain, as described repeatedly in this thesis, does not reflect that positive construct of midwifery. The communities of practice in which students learn do not consistently reflect the enthusiastic and passionate characteristics which would help in this development.

The question also remains as to whether education can ever be enough to change practice. The fairness of using students as change agents has been raised earlier; unless we recruit a particularly resilient type of student, this might be unrealistic or even immoral. However, without a change in the new midwives coming into midwifery, will we ever be able to change the existing culture? In the hierarchical system in Britain in general and in the health service in particular, is there a way that 'new world' values or freedoms can be introduced to increase the woman-centredness of midwifery practice without undue stress and pressures on students and newly qualified midwives? These questions indicate the need for the strategy to include coping skills for the dissonance which students may experience in order to prevent them leaving midwifery altogether.

This section of the chapter will consider several significant components to an educational strategy which will both look at the learning which takes place in the university and in practice. The impact of processes of learning, possible ways to create a new occupational identity and the situation of learning, both pre and post qualifying, will all be raised for consideration.

Content versus Process
Knowledge, understanding and skills in a wide but relevant variety of subjects, are fundamentals to any educational programme. As pointed out earlier in this chapter, students of midwifery will benefit from knowledge of the history of midwifery to understand its current position, politics of childbirth and the power relations within the health and maternity services. However, it is recognised that knowledge alone does not necessarily lead to action; skills and confidence for using this knowledge will be key points. Similarly, an understanding of the physiology of childbearing processes as well as the skills to effectively support these processes in order to help women achieve normal, physiological birth are fundamental. This will include understanding of anatomy and physiology, of best available evidence and of what women want from birth

experiences. The development of skills which will provide students with the ability to continuously meet the needs of women, in an autonomous yet collaborative way, are important. These skills will include assertiveness, critical analysis, decision making, communication / relationship building, group working, peer support and review, lifelong learning and creativity. Students will also need confidence in the significant impact skilled midwifery practice contributes to positive birth experiences.

Although the content of the programme of education will need to reflect these issues, it may be that the process of learning is a much more significant component. It would seem likely that the development of midwives who 'believe' will require an approach which will move beyond the established teaching and learning methods in popular use. Fraser et al (1997) point out that the majority of three year midwifery curricula that they reviewed focussed on the content of the programme (the 'what') rather than the process (the 'how'), although they recognise that the written curriculum documents and the actual programme may differ. In addition, in their study the emphasis of the content was in relation to the 'application' of 'scientific theory' especially biological, psychological and social science theory (Fraser et al 1997). Schon (1983) defines this approach to professional practice as 'technical rationality', a view of practice built around a single paradigm and in this case, the positivist paradigm of scientific knowledge. Schon (1983) suggests that this dominant view permeates higher education approaches and is built on the Western dogma of science as authoritative knowledge, as discussed extensively in chapters two and three. Fraser et al (1997) found that the midwifery education programmes start with a larger component of subject based theory, with practice playing a lesser part in the early part of the curriculum. Students are intended to learn science based theory (including physical and social sciences) which they then apply when they meet real cases in practice. The emphasis is on the content or facts rather than on the scientific process or principles. This approach to structuring a curriculum will embed the 'technical rationality' model early. Students will learn that scientific knowledge, which is used to a varying degree certainly initially, is a priority.

The teacher / student interaction in the first year of the midwifery curriculum is in large part based on theory acquisition (most timetabled hours are allocated to theory) and consequently on the transmission of knowledge as facts and information, which are then concurrently used to varying degrees in the context of

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midwifery practice. Such an emphasis on theory as facts and information may at the same time effectively change the student midwife's view of knowledge, and their learning strategies; students' view of practice could be influenced as well, the 'technical rationality' model (the application of scientific theory) becoming more firmly established.

Fraser et al 1997:33

The process of learning in these cases, therefore, is perpetuating the accepted priorities of knowledge; theory is more important than practice, science is more important than anything else. Students may be embued with values through the process of learning, in addition to the content of the course. A process which separates theory from practice and which prioritises factual knowledge early in the programme may not be enabling students to adopt woman-centred values from the outset of their study. If the programme of education is the shortened one for already qualified nurses, this approach may reinforce learning undergone in their nursing programme of study, as the 'technical rationality' model is common in nurse education as well. It is likely to confirm the similarity between nursing and midwifery rather than identifying distinct differences.

The process by which students are developed as midwives is a critical part of the educational strategy. Teaching and learning methods should be based on best available evidence as much as clinical practice should. The evidence reviewed in chapter four and presented in brief earlier in this chapter, highlights a number of key elements which should underpin midwifery programmes. These include active learning approaches, learning based on and in practice and a positive community of practice.

One of the teaching and learning approaches discussed in chapter four which may be a useful tool in the development of woman-centred midwives is that of enquiry / problem based learning. In an article which I wrote with colleagues shortly after implementing a problem based pre-registration midwifery curriculum, we drew analogies between the learning approach and woman centred practice (Thomas et al 1998:264):

Learning	Practice
student is the centre of learning	woman is the centre of practice
teacher facilitates (not takes control)	midwife supports (not takes control)
learning takes place in small groups	practice is undertaken in a team /caseload
student must take responsibility for learning	midwife is responsible for her practice
student is accountable to her learning set members	midwife is accountable for her practice to the women
student must communicate effectively with her colleagues	midwife needs well developed communication skills
student bases learning on best evidence	midwife bases practice on available best available evidence

Although this is not the only way in which the strategic vision of developing 'believers' could be implemented, there is a real potential for this teaching and learning method to have a significantly positive impact on students. As students are introduced to theory in relation to real case scenarios from practice and are involved in practice from the beginning of the programme, the 'technical rationality' model is avoided with its implicit priorities for theory over practice and science as the authoritative form of knowledge. Skills are developed throughout which help students to be prepared for supporting women effectively in practice. The process of learning itself helps to shape midwives with woman-centred values.

New Occupational Identity and Ideology

As discussed in chapter two, midwives in pre-industrial society were relatively autonomous and had control over their practice. They did not provide care in large bureaucratic organisations. There was limited hierarchy in the support of childbearing women before 'man midwives' became involved and therefore they were required to defer to few others (bar the Church authorities from the mid 16th century, but this would not have been on a day-to-day basis). The occupational identity of these important figures in the community would seem to have been strong; midwives had a distinctive and valued role to play in society.

This role has been eroded over the centuries with medical practitioners taking increasingly active roles in the provision of maternity care, especially since the majority of that care has taken place in hospitals. Midwives' sense of occupational identity has also been challenged as it has been aligned to the NHS structure of nursing. This has happened in the relatively recent past in three main ways:

- the move from the control by the Central Midwives Board to the UKCC in 1979 and now the NMC (see chapter two) where midwives are regulated alongside nurses and health visitors
- the move into hospitals where the midwifery management structures were created to emulate nursing ones
- the regrading of pay which took place in the 1980s in Britain when midwifery roles and responsibilities were described in relation to those of nursing to bring about a consistent pay structure across the professional groups

These developments have set a context in which midwifery may no longer feel as distinct and valued for its unique contribution as it did in pre-industrial days. Occupational identity has become more diffused through the alignment of midwifery to nursing and the move from birth in the community into the hierarchical bureaucracy of hospitals.

This study has identified two groups of midwives with fairly different and distinctive occupational identities, despite being part of the same overall group. The initial midwives interviewed, who work in a large bureaucratic organisation, were not able to 'make sure' that the woman's experience was consistently positive. The expectation that midwives should be able to 'make sure' on behalf of women seems linked to the paternalistic approach in the biomedical paradigm, with the professional as the expert able to find solutions for the lay public. This, coupled with the lack of perceived power within the organisation, seemed to have created frustration and a sense of impotence for these midwives. They did not articulate a personal ideology or political framework which underpinned their practice and way of working. They did not all really appear to 'believe' that they could support women in achieving their desired outcome.

In contrast, the autonomous midwives talked about feminism, strong women and political impacts on their roles. The autonomous midwives had all moved to a position in which the effect of a large bureaucracy was minimised and did not control their practice. This included independent practice, caseload practice and higher education; all of these positions require an ability to be self determining and offer the opportunity for relative control over one's work. This may have been influenced by their willingness to be open to new experiences, as was identified through the personality testing.

The educational strategy should foster the development of a clear and positive occupational identity. In order for students of midwifery to learn to believe in women and themselves, they will benefit from an articulated personal ideology which supports positive outcomes for women. Students will need role models who demonstrate these values and who help them to develop skills in dealing with others who unnecessarily interfere with normal processes. The community of practice in which students gain their practical experience will need to be seriously considered, and alternatives to the traditional maternity services identified for at least part of the practice experience, if the strategy is to be effective.

Situation of Learning

This study has identified several key issues which currently impact on the community of midwifery practice in the maternity services. Although the educational institution within which the programme of preparation is developed does not have authority over practice in the services where students gain experience, without significant changes to practice the strategy may have limited impact. The students may be prepared by new and meaningful educational methods in the university, adopting a positive occupational identity and skills for effectively supporting women. However if they then encounter practice which does not allow these to grow and flourish, they will experience the 'ideal / real' or 'theory / practice' gap discussed in chapter four. Therefore they will benefit from practice experience in environments where midwives do believe and where women birth without interruption so they can gain the confidence that the 'autonomous' midwives in this study articulated.

This presents enormous challenge. The proposals at the beginning of this chapter are long term considerations; waiting for the organisational structures in the NHS to

change does not seem an option. In addition, there is currently a serious shortage of midwives in this country; the NHS Plan (DoH 1999) has set ambitious targets for recruitment of students into pre-registration programmes to address this shortage. With very large numbers of students requiring placement for practice experience in maternity units, the opportunity to be selective about the type of environment in which to place them reduces. As the importance of the role of the mentor in learning has been stressed throughout this project, ideally students will be mentored by midwives who are able to put woman-centred values into practice. However these midwives may well be the exception rather than the rule; the particularly positive role models interviewed in this project had all moved out of the traditional maternity services due to frustration. The question as to how many midwives in traditional services, where most of practice experience is likely to be gained, are 'believers' is a difficult one to answer.

Alternative models of practice support, throughout the educational programme, may need to be considered to ensure the experience in practice is positive. Use of alternatives to the traditional model of care, provided in mainstream maternity services, could provide positive results e.g. birth centres, independent midwifery practices, caseload practices, international experiences. These types of practice may be able to provide very positive role models for students but they are still very limited in number. With the current large numbers of students, it is unlikely that even the majority, never mind all, could get this type of experience through their programmes. It may be important to ensure that students get this type of positive experience early in the programme as they are starting to shape their occupational identity. Periodic reinforcement could continue through the programme with students gaining some experience of the traditional service in between. Limited placements in alternative models could be spread out to best advantage for all students.

The development of specific teaching areas in practice, for example training centres / wards / units, which are staffed by appropriately prepared and motivated midwives may be a worthwhile investment as a means to significantly changing the current climate. These units could be linked to the university and staffed by lecturers who carry caseloads with students. The added benefit in this scenario would be the integration factor with the same individuals supporting student learning both in the classroom and in practice.

These suggestions have resource implications; however the potential financial gains in the long term may outweigh them as it is likely that midwives who support natural births with fewer expensive interventions will be the outcome. The psychological benefits to women must also be considered; potential gains in this respect are much more difficult to measure but are crucially important to consider. The cost of midwives leaving the service must also be considered as significant numbers do so after qualification as a result of disillusionment with the service. The cost of educating these midwives is then wasted.

The power which can be gained in partnership with women is another important element which could be embedded in the programme of education. In some areas, students of midwifery are themselves taking a caseload of women during their practice experience although the qualified midwives do not (personal communication - Bournemouth University, Thames Valley University). The student follows the women and is supervised by whichever practitioner the women meets during antenatal visits, labour and postnatal care. However, if the student arrives with a woman in labour having agreed her plan of care and finds that the midwife in charge of the case disagrees with the plan, the attempt to develop students as 'believers' could be completely undermined. This approach is certainly a possibility with less resource implications than others and it could lead to the same end (the development of a lasting, meaningful relationship with women, leading to students who are believers even if the midwives in the service are not). However there will need to be serious consideration given to the possibility that the student could end up in conflict between the woman and qualified midwife, if there is disagreement about the best form of care. If the relationship established was a successful one, the student would feel the need to advocate on behalf of the woman. This could create anxiety as the student may lack the confidence which comes with experience and the supervising midwife would be in a more powerful position, especially if she was assessing the student. This could undermine all of the good intentions of the approach.

The concern for all of these suggestions is that students will not be learning alongside mainstream midwives but then are likely to work with them on qualification. This could well set up tension between the two groups, a 'them and us' situation. However it may

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be unlikely that anything less radical will bring about a substantial change which will benefit women as well as midwives. With the percentage of Caesarean sections and other interventions of questionable value for routine use ever increasing in the current NHS, the evidence reviewed in this thesis suggests something radical is justified at this point. The creation, of a generation of 'believers' may be an answer to this virtual crisis.

The Strategy

The final step in this chapter is to synthesise the issues discussed into a clear strategy for midwifery education. I will identify the vision and some tactics which may be useful in achieving the ultimate goal. The detail is left to the curriculum developers.

The Vision

Programmes of pre-registration midwifery education will prepare midwives who believe in the ability of women to birth without intervention and who believe that midwives can help to make that happen. Experience will be gained in both the educational and practice environments, supported by effective teachers and mentors, to ensure they have the competence, passion and belief to succeed.

The Tactics

A variety of approaches can help to achieve this goal. This is not an exhaustive list but a synthesis of the issues already discussed, into a succinct plan, which will lead to this end.

Openness

Students will learn to be creative, analytic and reflective which will enhance their abilities to think differently and try new approaches. Creativity can be enhanced through the active engagement of students in their learning; although the ultimate outcomes in relation to the content of the programme are largely pre-set nationally, the means by which these are achieved can be negotiated with students. This may include learning contracts, in which the student decides how the outcomes are to be achieved, or any other active learning approaches which involve the student in making decisions creatively to that end.

Analytic skills will be developed through both the teaching and learning and the assessment approaches. The programme of education will be at an appropriate academic level to ensure students achieve the skill of critical analysis; this is likely to be at degree level. Critical incident analysis, based on actual experiences in practice, is one approach which has been successful in developing skills of analysis. There are many other possibilities which the creative curriculum developer can consider.

Reflection will be developed on both an individual and group level. Students will benefit from considering their practice analytically through the use of personal journals or diaries, discussion with mentors or personal tutors and in asking for feedback from women about their care. But they will also benefit from exposing their practice to the supportive critique of peers, as one of the groups of autonomous midwives discussed in their interview. Peer review as either a teaching and learning or assessment approach will help in developing midwives who are open to considering different ways of doing things as well as being able to be confident when being appraised by others.

Teaching and Learning Processes

Process is clearly an important part of learning; content can be transmitted to students in many ways but using teaching and learning approaches which develop and make explicit the often implicit or embedded knowledge and skills required for midwifery practice will benefit students. The use of enquiry based learning has been put forward as one such suitable approach. It is not the only one which could lead to this end; the key feature would appear to be in integrating theory with practice in a way which demonstrates value to midwifery knowledge alongside the theoretical perspectives of other disciplines. Rather than applying the concepts from other sources of 'authoritative' knowledge, the programme will foster a belief in the importance of midwifery as a discipline with a theoretical base equal to others. Learning subject based concepts within the context of their contribution to midwifery practice, rather than as separate entities to be applied, will be important. The ability to handle abstract notions will be encouraged through group discussion and debate, facilitated by skilled lecturers and practitioners.
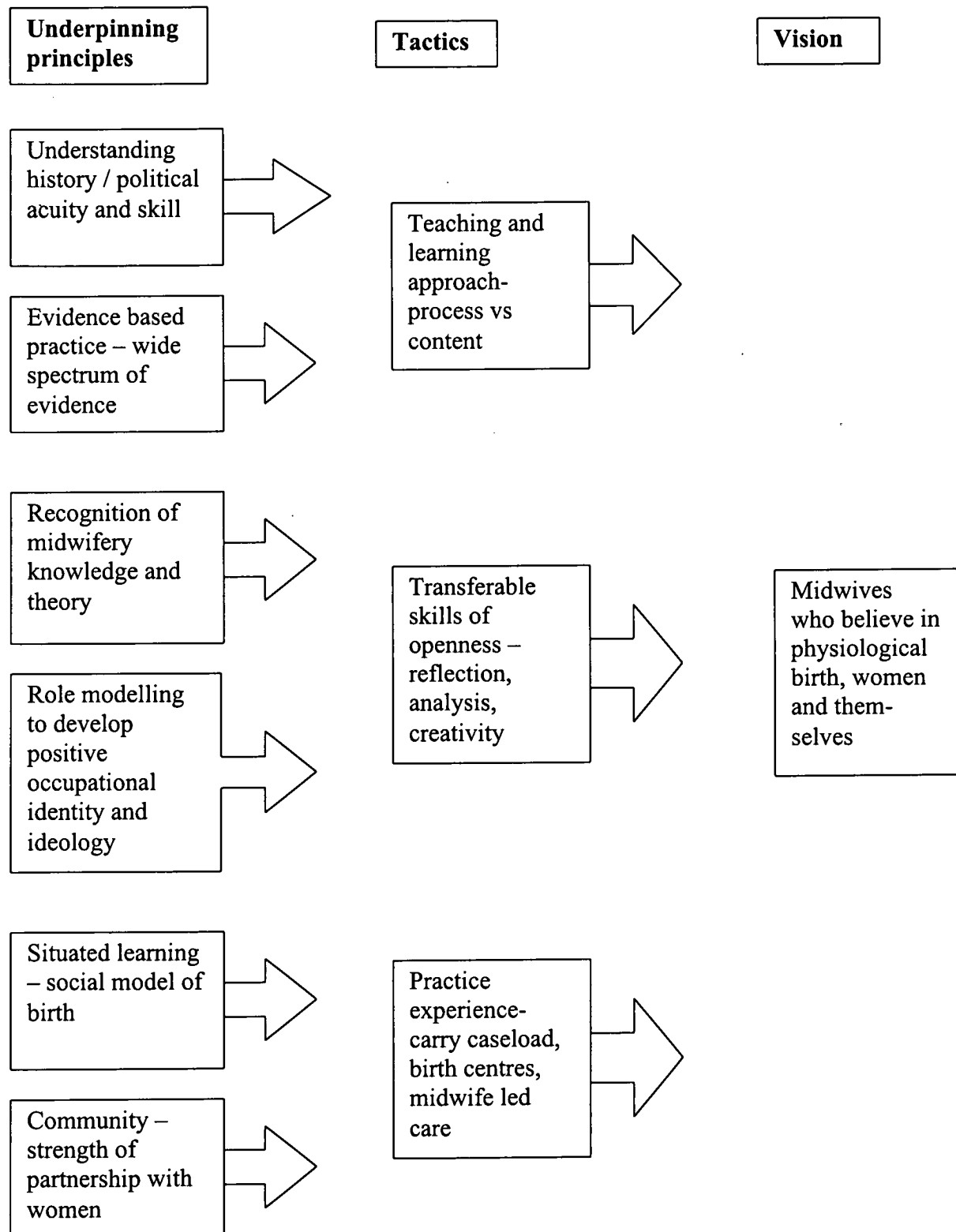
<u>Situation of Learning</u>

The values of both practice mentors and higher education lecturers will reflect the belief in women and midwifery. Practice experience may need to be offered in alternatives to the traditional maternity services to ensure students are able to see uninterrupted birth and the powerful impact a positive experience can have on women. Students may carry a personal caseload during their educational programme as an important way of developing a partnership with women. However the potential dissonance that this could cause between qualified midwives and students will need consideration. Selection of appropriate mentors in whichever practice environment the students are placed will be a key issue in ensuring they gain the right experiences to help them believe. Mentors will require preparation in order to ensure they are aware of the goal of the programme and able to support it. It may be that joint appointments between the university and practice, lecturer practitioners, as mentors could be a useful way of ensuring support for students is consistent across both environments.

Continued support for newly qualified midwives through preceptorship may also be an important means to maintaining belief after qualification, to prevent the vulnerable new midwife from going the path of least resistance if she / he is working in a medicalised practice area with few physiological births.

Conclusion

The ability to 'believe' is a basis for midwifery which has potentially significant benefits for childbearing women, in a culture that frequently favours almost routine technological intervention in birth. A strategic approach to pre-registration education, which articulates a clear vision and some possible tactics, may be a useful tool in developing woman-centred midwives who are able to support women to achieve their desired outcomes. A diagrammatic representation of the strategy is presented to demonstrate the integration of the findings:

Strategy for Learning to be a Midwife who Believes

Underpinning principles

Tactics

Vision

Understanding history / political acuity and skill

Evidence based practice – wide spectrum of evidence

Teaching and learning approach- process vs content

Recognition of midwifery knowledge and theory

Role modelling to develop positive occupational identity and ideology

Transferable skills of openness – reflection, analysis, creativity

Midwives who believe in physiological birth, women and them- selves

Situated learning – social model of birth

Community – strength of partnership with women

Practice experience- carry caseload, birth centres, midwife led care

This thesis has presented a journey in which I have explored important issues about the process of learning to be a midwife. Although I have made suggestions about possible ways forward, this is a complex situation with many interrelated factors to be considered. Possibly more questions have been generated than answers; there are a number of areas where further work and research could contribute to achieve the ultimate goal of woman-centred midwives. In respect of the theoretical basis of midwifery, the articulation of implicit knowledge, providing an alternative perspective on physiology from that accepted in the medical community, could provide substantial benefit to women. Work to extricate this knowledge could make a substantial contribution to the value of midwifery practice (as opposed to medical or nursing practice) and the status of midwives. Making this knowledge available to students explicitly could accelerate the development of skills in non-interventionist support for women.

In respect of education, further research is needed to determine the effects of new approaches to teaching and learning and whether these benefit women. These include comparing outcomes for students who experience caseload practice during their educational programme, the long term effects in practice of enquiry / problem based learning or other active learning methods, the significance of methods which develop creativity, analytic and reflective skills.

Despite the goal of this project being the development of an educational strategy, I recognise that education may not be enough to bring about the significant change which would lead to a new 'breed' of midwives, the 'believers'. The culture of practice in current maternity services will require significant change in order for this type of midwife to want to stay and practice there, rather than escaping from the inherent control and pressure as the 'autonomous' midwives whom I interviewed did. If the 'believers' all leave the traditional maternity services, students will rarely gain the experience desirable to shape them positively and so a cycle is set. However there needs to be a break made in this cycle somewhere; as both an educationalist and a 'believer', I feel that a strategic approach to programmes of midwifery education, with a vision of a generation of 'believers', may be one way of helping to bring about positive change.

Epilogue

Reflexivity

> Reflexivity means reflecting upon and understanding our own personal, political and intellectual autobiographies as researchers and making explicit where we are located in relation to our research respondents. Reflexivity also means acknowledging the critical role we play in creating, interpreting and theorising research data.
>
> Mauthner & Doucet 1998:121

As identified in the section on 'practitioner research' in chapter five, there is a challenge in being part of the group being researched; being a midwife means that I have brought practitioner knowledge, a set of values and priorities, and extensive experience to this project. As discussed earlier, I have made attempts to consider the impact of these throughout the study. This started with undertaking the 'personal construct' exercise (in appendix one) where I articulated, in a laddering procedure, both my ideals and opposing concepts at the outset. In addition, I have maintained a reflective diary throughout the project to identify the feelings I have experienced during the data collection and analysis phases and where I have recorded 'extra' experiences which have impacted on the development of the study which were not directly involved in the data collection process (for example the discussion of the experience I had in teaching gynaecology nurses about labour in chapter three). I have also discussed my approaches and findings with my supervisors throughout the project to help me to see objectively any influence I have had on the processes.

Steier (1991) identifies that there are two ways in which reflexivity can be used, in the immediate (small circuit) or in the longer term (long circuit). In this epilogue, I would like to acknowledge the critical role I have played in this study, raised in the quote above from Mauthner & Doucet as important, as well as undertaking Steier's 'long circuit' reflexive contemplation. I will also highlight limitations in the study and propose areas of further research which may lead on from this project.

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The Effect of my Personal Stance on the Research

Sample Selection and Data Collection

Reed (1995) suggests that practitioner knowledge may be particularly helpful in selecting both the sample and setting of a study. Understanding the context (or 'insider knowledge') may lead to a selection which is very pertinent to the research and leads to the production of results which are meaningful to practitioners. Reed (1995:50) identifies that some studies may seem naïve or misguided because 'insider knowledge' has not been used; the findings do not seem appropriate to practitioners as the setting or sample may not have been ideal to solicit the desired data.

My 'insider knowledge' led to the selection of the two samples in this study. There was lengthy discussion with my supervisors about the first sample; would there be any advantage to interviewing midwives in other parts of the country or in different maternity units in the south east of England? In addition, would it be preferable to select a maternity unit where I was not known? As the sample size was likely to be relatively small with the chosen method, there seemed little advantage to interviewing a few midwives in a number of different units, especially as I may not have the 'insider knowledge' as to the type of unit (medicalised, midwife led, etc). It seemed more important to purposefully select a unit which had a reputation as being quite 'middle-of-the-road' i.e. not heavily dominated by obstetricians but also not on the cutting edge of midwifery developments. The sample within this setting did reflect a number of differing midwifery perspectives within the unit- team, core, management and link lecturer roles. This provided some diversity despite the sample being from within one service. In respect of being known about in the unit, there was a comfort zone in certain respects to that issue as it did help in getting access. However possibly more important was the willingness of the midwives to participate in the study which may not have been so forthcoming in a unit where I was unknown. As I pointed out in chapter six, this 'being known' did not seem to affect the midwives' ability to speak openly about both the ideals and reality of their practice.

The second sample was selected as a result of the identification of the disempowerment, at times, of the initial midwives following analysis of the data

from the first sample. As highlighted in chapter seven, I wanted to find midwives who were practising 'autonomously', who were not in disempowered positions. On reflection, this led to this sample being defined by place; they were all practising outside of the traditional British maternity service although place was not the selecting factor. Despite some being employed by the NHS, that group were caseload holders and working in a very different way to the majority of midwives. I could have selected a total sample of midwives in local services who were in more autonomous positions than the norm; this may have presented some challenge as my 'insider knowledge' did not provide me with an obvious group (consultant midwives were not in post at the time; should this study be undertaken at this point in time, that might be an obvious group to consider). On reflection, the vision, passion and ideals which this group espoused (the degree of which I had not really anticipated) helped to provide a dimension which may have been particularly helpful in creating an educational strategy and which may have been difficult to find in traditional maternity services. The creative tension between the ideal and the real (as discussed in chapter four in respect of the 'theory / practice gap') has helped me to think about the experiences of that second sample as important to emulate in the strategy.

Therefore, I could have selected different samples for both groups interviewed but have no regrets about the choices made. My personal stance, as identified in the personal construct, was more aligned to the second group interviewed but that was not the starting point of the project (I did not look for midwives with the same values as mine). I ended up with that group as a result of finding frustrations in the initial sample which were much more prominent than I had expected. Possibly the most significant learning which I have experienced is in the recognition to the significance of working in a large bureaucracy. Rather than placing the burden of responsibility for limited woman-centredness on the individual midwife, I have realised that the environment is crucial to the type of midwifery practice and to the learning opportunities for student midwives. The development of skills which can help in dealing with the bureaucratic nature of services seems as necessary as the development of the practical skills of midwifery at this point in history.

Data Interpretation

> A profound level of self-awareness is required to begin to capture the perspectives through which we view the world; and it is not easy to grasp the 'unconscious' filters through which we experience the world. In other words, in analysing data we are confronted with ourselves, and with our own central role in shaping the outcome.

> Mauthner & Doucet 1998:122

Analysis of the data in this study was based on the grounded theory approach. Despite following the conventions of the method, I acknowledge that my interpretation of the data is based on my value base, as is the case with all qualitative researchers. Reed (1995) highlights the 'analytic leaps' which may result in researchers simply perpetuating their existing views rather than in challenging them. However, she goes on to point out that an 'open mind' is not an 'empty mind'; the challenge for researchers (especially practitioners undertaking research) is to consider their own knowledge as provisional rather than fixed (Reed 1995:60) and be receptive to new understandings despite not starting with a blank sheet. As I shared in chapter six, my first cut through the data in the first sample, led me to creating codes which seemed to fit the issues. My supervisors helped me to look at this differently, to use the midwives' own words to create the labels given to the codes and then categories. This approach continued throughout the project with continual efforts to put aside my values and to 'hear the voices' of the midwives interviewed in both samples. I cannot dismiss myself in this process, any more than any researcher can, but I feel that I have learned a great deal about my assumptions regarding midwifery practice especially in the climate of the current NHS. I feel that both the data themselves and the literature used to expand them have corroborated the trustworthiness of the findings either despite or because of my personal interpretation (see appendix seven for how trustworthiness has been assessed through the project).

Limitations in the Study

In chapter five, I have identified some limitations in the study which related particularly to the data collected in the first two phases of the research ('being known' by the initial midwives, the relatively small sample sizes of midwives

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interviewed). I have also identified the limitations of both the general issue of testing personality through trait analysis and the lack of generalisability as a result of the small sample size in chapter eight. This discussion relates more to the study as a whole, the limitations of having undertaken this particular research as the foundation of an educational strategy.

When I wrote the proposal for this research, my intention was to develop an educational strategy which could be tested with groups of students midwives to help develop woman-centred approaches. However, my starting point was planned to be the building of a strategy based on evidence of key concepts in midwifery; in reviewing the literature, this evidence base seemed quite thin. Therefore I moved to a different place, to the development of some midwifery theory / concepts which would help to underpin programmes of education. The resulting theory (or key concept of 'believing') has significant implications for the situation of practice but the links to education had to be drawn out. Possibly the most important implication of the findings is in relation to the structure of the maternity services rather than in using education as a change management tool. Several times in this thesis, I have discussed the difficulty and fairness in using students as agents of change. Moving from the bureaucratic environment of care in which midwives practice and in which students learn appears to be the most significant implication of the study yet that is beyond the scope of the project. The strategy developed does provide opportunities for students to learn in alternative settings so they do develop woman-centred values and skills. But, without a significant change in the patterns of care, the strategy may have limited impact.

In addition, the strategy needs to be tested. It is an ideal, a means to an end which has not been tested within the project, as was my initial intention. I recognise that it may or may not prove helpful if it is implemented. At the time of writing this epilogue, the Royal College of Midwives (RCM) has just produced an educational strategy. There are similarities to my findings but there are also marked differences. The need to consider the implications of the bureaucratic NHS is largely missing from the RCM's work but there is acknowledgement of the advantages of a national midwifery curriculum to ensure a consistency that is

currently lacking (as identified in chapter four). It will be a challenge beyond the project for me to influence that national curriculum with my findings.

Further Research

There are a number of areas of further research which can be extrapolated from this very broad project. As just discussed, researching the impact of the educational strategy is one, both looking to see the implications for the students themselves as well as for the women in their care. There is also the desirability of making explicit midwifery knowledge of physiology, to facilitate the move from the persisting oral tradition to one which is both recorded and researched, in order to have a foundation to challenge the existing biomedical authoritative knowledge. Delivery of care in alternative settings, outside of the large bureaucratic NHS, as preferable environments for both women and students of midwifery deserves further exploration to determine whether women and midwives benefit from practice in midwife-led environments.

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Appendix One

Appendix One

Personal Construct Exercise

This exercise starts the data collection for my research project on a theory of midwifery. Using the laddering exercise described by Kirkham (1995) and based on Kelly's (1955) work on personal constructs, I wish to identify the key issues which I perceive as essential to effective midwifery practice. This step should help me to clarify my stance, and therefore my biases, prior to interviewing midwives about their concepts. The principle of reflexivity, or the need for the researcher to accept the knowledge she has and treat it as valid in its own terms (Hammersley & Atkinson 1983), indicates that it will be useful for me to articulate my position so that I can value my own knowledge as part of the larger project.

The background assumptions that I make prior to describing my personal construct is that I apply these concepts to a midwife who has the knowledge and skills to be a safe practitioner. This goes beyond the realm of merely being able to act appropriately in emergency situations; safe to me means that the midwife is well informed on current evidence and debate and integrates this knowledge into her every day practice. For example, safety does not stop at knowing the steps to dealing with a primary postpartum haemorrhage; it extends to ensuring things like the ten steps to successful breastfeeding are implemented in her practice.

Construct	Opposing construct
Needs to be able to listen effectively	Does all the talking
Open to the needs of individual women	Has a prepared package to offer (expert advice)
Supports women in their decisions	Takes control- feels she knows best
Declares personal biases in information	Pretends to be giving neutral

giving (therefore must be aware of own biases- willing to scrutinise herself)	(not value laden) information
Reflective- willing to change	Stuck
Views birth as a social event	Medical perspective
Wants the best outcome for each woman (as defined by the woman)	Wants to be considered a 'good' midwife by other professionals
Prepared to advocate/ defend woman's Wishes (stick her neck out)	Afraid to rock the boat- defensive practice to cover her own back
Assertive	Controlling
Gives of self- willing to be a friend	Hides behind professional face
Really cares about women	Cares for women
With woman	With self

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Appendix Two

Midwifery Studies					
Study	**Design / Methods**	**Setting / Participants**	**Aim**	**Themes**	**Notes**
Begley C. 1999, 1999, 2001	Triangulation: qualitative & quantitative. Phenomenological approach. Focus grps. diary keeping, questionnaires.	Southern Ireland. All students in 1995 in all schools (2yr programme).	Interpreting & understanding the working & learning world of students.	'Workers not learners'. 'Getting the hang of it' – the problem of short allocations. 'a do-it-yourself course' – good interpersonal relationships make a big difference. Emphasis on service commitment not learning needs. 'learning to be a midwife' - trial & error for practical midwifery skills. 'thrown in the deep end' 'a whole new ball-game' – difficult to get used to working in midwifery. There was little or no time left to teach or learn. 'it's all routine' – work mainly tasks rather than holistic care. 'gaining confidence & competence' – being given increased responsibility, partic nights, gave more confidence. Qualified staff missed opportunities to teach. 'giving midwifery care' – bullying behaviour 'get on with it' Students suffered from a role of conflict and loss of status.	Acute shortage of staff at time of study. Student midwives employed as part of the work force.
Fraiser DM. 2000	Action research. Interviews, observation & documentary analysis	7 institutions in England. 61- 3 year pre-reg midwifery students	To identify factors which facilitate & inhibit the effectiveness of the current pre-reg programme	- Student feelings of confidence & competence: majority of students interviewed felt well prepared for the role of midwife. Aspects most instrumental in preparing students for 1st job – their practice-based assessors & students own personality. Being given additional responsibility in the last few months help build confidence. Feeling competent influenced by whether students expectations on whether it was reasonable to learn some skills post reg or be able to provide all care. - Achieving statutory requirements: a common deficit, the lack of experience of episiotomies. The most difficult to achieve as a student –	These were direct entry students. A problem was the difference in culture between higher education and the NHS.

				assigning duties to others & supervising and monitoring these. • Commitment to the role: very committed and keen to work in teams & group practices. • Responsibility & accountability: except for a few, new midwives coped well with the transition form student to qualified practitioner. Short-staffed situations and being 'thrown in the deep end' affected the transition. • Career development: new midwives have little time for consolidation in their first post. Not always equipped for busy, short-staffed, litigious-conscious maternity services	
Woodard V. 1999	Ethnographic study: observation & semi structured interviews	UK NHS settings. 7 midwives & 6 nurses.	Comparing a palliative setting with midwifery hospital setting to assess the potential contribution of formal theory to m/w practice.	• Caring practices eroded in maternity setting. Practice often routinised, task-orientated and sometimes unresponsive to women's needs, where as care in the palliative setting was receptive, responsive, and attentive to the patients person & experience. • Nurses had better interdisciplinary relationships with medical staff than midwives and relative autonomy. Shortage of midwifery staff led to routinisation of care and less motivation to appraise and develop practice.	Did not involve students. Palliative care better patient-staff ratio. Stays shorter and more rapid turnover of women in maternity care.
Currie SM 1999	Qualitative research. In-depth interviews using grounded theory.	Scotland. mid 1990s 18month post reg 7 student midwives & their midwife 'supporters' & 4 night duty midwives.	Investigate the preparation of student midwives for autonomous practice.	9 categories with 3 major themes. • Recognition: Good communication skills. To challenge a decision need an adequate knowledge base. Students avoided conflict & confrontation. • Incorporation: 'doing as your told' expected by some midwives and the easy option. Conflicting advice often referred to. In community students encouraged to communicate with drs directly – this increased confidence and improved interpersonal skills. • Facilitation: clinical supervision took place at a distance. If unsupervised may not ask and learn from trial and error.	

				• Level of supervision dropped off sign in community. This considered a positive learning environment – senior students worked alone, this appeared to improve self-esteem & learning. • Discrepancy between night & day shifts. Night more relaxed & reduced presence of medics, therefor increased autonomy - viewed positively. • Stress not referred to directly, some interactions caused stress eg. the way criticism is handled. • Students admired midwives- honesty, empathy, good communication & not panicking. • Neg qualities included – misuse of power & lack of assertiveness	
Yearley C. 1999	Ethnographic. In-depth, semi-structured interviews.	England Pre-reg students. 3yr university programme	How pre-reg students experience & attempt to learn to work in a clinical environment.	Key themes; • First impressions: 'culture shock' of 1st days. Feelings of helplessness in terms of lack of clinical skills. Having no previous nursing experience found different ways of coping eg, taking in books, making tea – ways of 'looking busy'. • Making relationships: All received neg responses from m/w for being pre-reg students. In order to gain acceptance the students relied on their existing social skills & competencies. • Learning to 'fit in': Aware of being perceived as 'different' from other students. The problems of leaving behind the familiarity & security of a previous social status. • Positive feedback: was a real boost to students' confidence & greatly valued.	
Chamberlain M 1997, 1996,1991	Ethnographic, grounded theory. Observation & interview.	English, large urban maternity hospital. 25 students (5 from 5 sets) Post-reg. 18 month course 1988-9.	Original PhD on factors which affect the learning of clinical skills by student midwives.	2 major findings identified as having a major impact on student learning: • Role transition; problems midwifery students encounter when changing from nurse to student. • Communication for learning purposes. Lack of appropriate info given by m/ws. This could be enough to carry out a task only, no info given when requested by a student, info with a large	Papers from data collected for unpublished PhD thesis 1994. Data collected prior to university programmes & ENB 994 course

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amount of terminology.

Midwives tended to use methods by which they had been taught:

- Observation: Used as a teaching strategy for all new students. Unlike hospital m/ws community m/ws would provide feedback in addition to observation.
- Show & tell: Lack of clinical supervision a common problem. Also assumption of a single explanation with 1 demonstration being sufficient. The needs of the service because of staff shortages frequently referred to.
- Indirect learning: Students obtained info by listening to midwives interactions with women, drs, each other.
- Trial & error: The main method of learning by students in wards/clinics., the assumption being you have to 'do' to learn, partly due to staff shortages. 'Thrown in' – left on their own with little or no explanation

Factors interfering with learning:

- Anxiety; major cause poor supervision on labour ward. Also that the role & function of the m/w as taught in school bearing little relationship to clinical environment.
- Conflict in the workplace.
- Students regarded as service staff rather than students to be educated.

Factors assisting with learning

- Personality of student
- Motivation of midwife for teaching; midwives most effective were confident in their own skills & interested in teaching. Usually experienced m/ws with good communication skills.
- Opportunity to learn

2 styles of learning identified; active & passive.

Methods m/ws use to teach have changed little over the years.

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Cavanagh SJ & Snape J 1997	Qualitative study. Questionnaires. Stressful events recorded as a little, much, very much. Recorded incidents in their own words.	12 collages in England over a 3-month period. 500 questionnaires distributed, 199 usable returned. ?127 pre-reg & 74 pre-reg (shortened).	Paper part of a study to investigate the sources of stress experienced by student midwives during clinical & academic parts of course.	The 'very much' causes of stress in clinical setting: • Treatment of women • Behaviour of doctors & midwives • Dealing with certain procedures for the first time. • Working with insensitive & uninterested staff • Being expected to take high responsibility role when it suited placement managers. Many students singled out the apparent shortage of staff at some time during their placements & that staff were extremely busy had adversely affected the learning environment The greatest concern was in finding suitable employment after qualification.	Only 199 questionnaires out of 500 included.

Mander R 1994, 1989	Longitudinal prospective study of 2 cohorts of midwives. Postal questionnaires, one at the start on at the end of the course. Examination of intention to practise records.	Scotland. A comparison of midwives following a 12 month course (n303) with an 18 month course (n397).	1. To draw a profile of student midwives in Scotland 2. To study the relationship between employment plans & actual employment. 3. Examine factors influencing midwives' employment, in partic those associated with the course.	Reasons for taking m/w training:
				• Differed little between the 2 cohorts
				• Only a minority wished to practice midwifery 12% & 15%.
				• 2 biggest reasons – to satisfy own interest & complete general training.
				Factors associated with practising midwifery:
				• those with 'A' levels or equivalent statistically more likely than those who had not to notify intention to practice.
				Socialization:
				• appeared to increase with the extension of training
				  - ? due to increased length of course
				  - ? due to more appropriate self selection
				• no significant diff in confidence in midwifery practice (? unrealistic expectations at beginning of training)
					Response rate:
					• beginners 72%
					• completed 58%

Davies R 1990, 1991, 1996	Qualitative study. Ethnographic study. Interviews, group discussions & diaries.	School of midwifery in a district general hospital in UK. 9 student midwives in the first 18 weeks	To examine the differences & similarities between nursing & midwifery through the eyes of a set of	Themes: • the midwife as a practitioner in her own right – rhetoric or reality. Rhetoric- in classroom students constantly exposed to the rhetoric that the status & power of m/w are equal to an obstetrician. That m/ws make decisions	

		of training	student midwives.	independently of medics. Reality- Students attributed the inability of midwives to work as practitioners due to controlling medics. • Transition from the role of 'competent nurse' to student midwife. • Strategies students learn to cope with their anxiety ; 1. focusing on ritulized & routine aspect of work – 'doing the obs', a tried & tested confidence booster. 2. 'learning to be taciturn' - best to say nothing. 3. 'sussing and sizing' – students v competent at this with clinical staff & ward atmosphere • Compromise between the provision of service & education of student.	
Robinson S 1991, 1986	Quantitative study. Survey by questionnaire. Mostly closed questions.	England and Wales. A comparison of midwives following a 12 month course in 1979 (n932) with an 18 month course in 1983 (n931).	To explore whether • m/ws felt they had sufficient clinical experience in training • views on clinical & classroom teaching • how the course had prepared them • reasons for training & career intentions ascertain any differences between the 2 groups.	Reasons for training: (in order) 1. 'to broaden my experience' 2. perception that it improves nursing career prospects. 3. training incomplete without m/w (1983 signif less likely to say this that 1979) 4. intend to work as a m/w after qualifying (1983 signif more likely than 1979) Clinical teaching: • Majority of both groups felt they did not have enough from hospital m/ws. • Reluctance of hospital m/ws to teach • More than ¾ of both groups had enough teaching from community m/ws. • Tutors spent too little time or none at all Clinical experience: • Majority of both groups felt they needed more time, specifically in theatre, NNU, labour ward. • 18 month course more likely to say they had sufficient clinical experience Enjoyment of training: • initial training most reasons given were about not enjoying the course. This included 1. lack of staff recognition of knowledge gained during nursing	Over 80% response rate

				2. difficulty adjusting to being a student again 3. lack of knowledge & experience to provide care • community experience – time most likely to be enjoyed. This included 1. having time to spend with women 2. providing continuity of care 3. learning in a 1to 1 relationship with a m/w. 4. opportunity to practice with some independence. Career intentions: • those over 30 signif more likely, in both groups, to say they intended to make a career of midwifery. • 18month signif more likely than 12 month course to say they intended to make a career of midwifery.	
McCrea et al 1994	Questionnaire	Republic of Ireland. 2yr training with a substantial amount in clinical setting. 42 students completed questionnaires (a 64% response rate)	An investigation into the learning experiences of student midwives in the clinical setting.	Factors which influenced students experience of 'learning on the job'; • the quality of clinical teaching • the way trained staff practice Majority (83%) of students felt they were primarily a 'worker' on the wards. Students learnt from senior students or trial and error. A shortage of staff / staff not trained to teach. Previous nursing experience influenced students' perception of midwifery. 'midwives are not allowed to practise their independent role'	A small study.
Reid M 1986	Qualitative study. Participant observation	America – 10 states. 'Snowball' sample of 49 lay midwives. Research completed 1982.	Explores the unorthodox training of American lay midwives. This is usually by self-tuition &/or apprenticeship. Describes how the m/w learns through talk, touch & sight.	Selection of apprentice & teacher: • Relationship sometimes likened to a marriage • 2 partners may only know if they are compatible after a trial period • Personality is crucial. Early stages: • Apprentice expected to observe the senior midwife • An import function seeing numerous births Move on to Touch & Sight • M/w rely on the senses, touch, sight, hearing. • Touch v. important eg learning VEs & palpation.	Although concerned with 'lay' American apprenticeship it is suggested that this may help to understand the process involved as a student trains to become a midwife.

				Verbal / non-verbal communication	
				• Talk a major medium through which the senior midwife passes on her skills	
				• As time passes rely more on non-verbal communication. The value of having the same teacher import. here.	
				• As more experience gained the relationship is more akin to a partnership.	
				Learning to present as a midwife	
				• Requires a role model	
				• An import. element of creating/maintaining the woman's confidence is projecting the image of a midwife.	
				• Learning to act as a midwife comes with greater familiarity with the role.	
				• Increasing confidence a sign the apprentice is nearing the end of training.	

Appendix Three

Interview Transcript	Memo
Interview 9 1: If we just stay with the concept of a risk a bit more, you talked about the woman with the hysterectomy and now the woman with the fetal heart, are there any other situations where things became complicated and you think this issue of a safe environment was important? P: I had a lady here who had twins, it was her second pregnancy, she had a little boy. Everything was grand in her pregnancy, everything was normal and then in labour she got to 10 centimetres, she was about to deliver her baby and this doctor, this registrar comes in and said to me 'Right what's happening – how is the second baby coming? Do this..do that..' and when I was delivering the first twin he says 'Right. Let's do an epis.' for the first twin like and I looked at him and I said 'no' but he took over straight away instead of looking at what was happening and he said 'Do an epis' I said 'no, she's had a baby before and it's a small baby. I've felt and there's plenty of room. She doesn't need an epis'. He said 'but what about the second twin? We always do epis for twins.' I thought but what about if the second twin doesn't come straight away, look at all the bleeding she's going to have. He kept at me to do it and near the end because the paed was looking at me and the parents were looking at me, I said 'yeah, yeah, o.k.' and didn't do it but I got everything ready and then a G grade sister comes in and I asked her if I should do an epis for twins and she said 'yeah, yeah, yeah' but she didn't listen to me she was busy getting things ready. So because I'm new here and she said yes I thought well I'd better do it then, so I did it and the next twin didn't come til about 25 minutes later and the woman just bled and bled the whole time. She didn't need an epis, I know she didn't but he came in and ordered me to do it and the whole situation with the parents looking at me, it put a strain on them, there had been a relaxed atmosphere, everything was happening normally and he just put a whole different thing…	Everything was normal til the doctor came in-what changed – the actual situation or the perception of the situation? As this case was one of potential 'risk', it opened the opportunity for control to be removed from the midwife. It wasn't actually complicated but the fact that it was a twin birth meant obstetric control was assumed. The midwife was new and felt powerless to challenge the doctor's order, especially in front of the parents. She knew she was right, wanted support from a midwifery colleague but didn't get it so followed the order even though she knew it wasn't in the woman's best interest.. Interference in her decision-making stripped her of control in the situation and may have affected the woman's trust in her ability. Everyone was looking at her to see if she would give in which she did in the end, knowing it wasn't the right thing to do. Cases of potential risk can lead to inappropriate interference – it would have been better for all if that doctor hadn't even come into the room but the midwife felt powerless to change that as it was custom and practice in the unit where she was new. Interference/removing control Giving in/no peer support Guilt about not doing the 'right' thing Betraying woman's trust?

Interview Transcript	Memo
Interview 10 P: Yeah, I had a lady recently who I hadn't actually got to know on the team which was unusual for our team because we do usually manage to meet all the women...(can't hear)... but she wanted a water birth. I was very excited and she was excited because it was her first birth and to me it was my first water birth, if we get there. Very early on, even on the phone, I'd been talking and liaising with her but I'd never seen her. Over the actual day, I'd spoken to her twice on the phone, actually it wasn't her I spoke to, it was her husband who was very friendly. So when she came in, it felt as if we had already met although we hadn't. So I looked after her from about 8.00 and I called in my manager, Mary to be second midwife. Communication between us was lovely, I was able to give them the space they needed, cause they were in the pool and to allow them to do whatever they wanted as in bringing in candles.. anything to make the environment their own. Me and her, we did hit it off; it was lovely especially at the end, when there was problems and we felt comfortable with each other. She was able to listen to me and then the experience at the end, she ended up with a Ventouse so it wasn't actually a very happy delivery at the end. It wasn't the experience that she wanted but she was quite happy at the end of the day, that the baby was well and she was O.K. I ended up detaching myself a bit at the end cause I'd been up all night but I still felt when I transferred her up to the ward in the morning, there was still a lot of goodwill between us even though she didn't have what she wanted. She still got her beautiful daughter but she didn't have the delivery that she had wanted. I: What did you do to help her feel that, even though the situation was changing, she wasn't going to be able to carry on in the way that she hoped, how were you able to help her to come to terms with that? P: I was giving her time and discussing with her, although we didn't have a lot of time, we were able to discuss what was going on. I was able to	Both midwife and woman excited about water birth – felt very 'special' – had made contact before the event, the midwife was clearly feeling good about being able to make a difference for this woman. Moving from 'special' to 'satisfactory' – it ended up not being what the woman wanted but it was 'o.k.' – both mother and baby well (bottom line). The midwife started to feel that she was no longer 'making a difference'-? is she using the excuse of being up all night as a way of convincing herself that it was O.K. to detach herself, maybe at a time when the woman would need her most? The role changes – she isn't able to control the positive environment any longer – she had to invite others in to participate in the care and now

Appendix 3 continued

Interview Transcript	Memo
give her full feedback. The doctors were coming in and they were saying things and then walking out; I was able to stay with her and say 'This is what's happening. Do you understand what's going on?'. They were able to talk to me and ask about what was going on. Everything that she'd written on her birth plan didn't happen, which can happen but she could understand that we weren't doing things just to go against her water birth and everything. We were actually doing it because she'd been a long tine in second stage. It was the fact that I was the same person who had been there, I was able to talk to her and she was able to say that she was annoyed about certain things and whatever, it was helpful for her. It was the same face rather than somebody else new just coming in at the end. So I think it helped that I was there all the time but there was one stage, when she was having a Ventouse, when I could feel myself detaching, cause I was very tired, I thought I sort of had to separate. There was a student nurse who came in, a student midwife came in at the end, she'd already met the student midwife and she had…That was good because she'd already met the student and she'd seen her before she was present at the delivery to observe, she was another face that she'd already seen and who she knew, so that was handy. I felt that I had to detach to get myself back to who I normally am without being tired so she understood that and at the end, we were back to being as we had been. I: How, in terms of the doctors becoming involved because of the long second stage, how did that affect the environment once the doctors moved in? P: Well we were all normal, everything had been normal and it was going to be as natural as possible, as much as we could and at one stage, we broke the waters and there was meconium but it was very light meconium and she was eight days over so we thought O.K. everything has been normal so we could listen in to check. The doctor walked in and said 'O.K. we need a continuous tracing in here'. All of a sudden, we were	she was explaining and interpreting the decisions of others. She was trying to help the woman to make sense of the situation but seems to be feeling bad that things have changed – the 'special' is disappearing. Seems to be trying to feel good about being the continuity link through the whole situation but this seems a much less satisfying role. Back to detaching herself – student nurse and student midwife become involved in supporting the woman justifying her detachment by saying that the woman had met the student previously so there was some continuity. Was feeling out of control the situation part of the reason for her detaching? Not feeling she was making the difference any more may have reduced her commitment to supporting the woman – it didn't feel special any more. Moving from normal to abnormal again; everything felt normal until the membranes ruptured and there was meconium. The evidence of potential complication could not be ignored – even though she seemed to be trying to convince herself that it could be normal e.g. post term. The arrival of the doctor led to interference again; both mother and midwife did not want what was suggested but gave in despite feeling that the

Appendix 3 continued

Interview Transcript	Memo
just going from normal to abnormal within seconds which neither of us liked. The two of us, I was even getting my back up thinking well everything has been normal so what's the problem?	fetal heart was not indicating any problems. Control was removed; the midwife moved to balancing between the doctor and the woman, making a stand when the doctor suggested too much interference (FSE). Taking a stand.
I: Did you? Put the trace on?	
P: I did but I discussed with the lady and said 'We need to put it on' and he even said we should put an FSE on and I went 'No'. There's a good trace and there's nothing wrong'. That's when I actually said no because I was being her advocate as much as I could. I think that helped as well but it was hard watching everything go from normal to abnormal within seconds but it does happen but it was just that I was feeling…	Advocating – balancing the woman's wishes with the doctor's orders. Disappointment at the 'loss' of normality.
Later on interview 10	
Recently, with this lady with the water birth, I was actually in the room when she was having her epidural and I was nearly in tears which is unusual for me, very unusual, I think it was because I was tired as well. But I just thought 'I don't believe this, just everything is going the wrong way'. But afterwards, because I was able to talk to her about it, I haven't been able to go into full depth with her, but I've talked to her a little bit and I could see that she was happy then I felt happier. I didn't feel guilty but disappointed but I didn't feel as if it was my fault. I didn't feel as I did anything wrong. What we did was good and to actually have my manager say to me afterwards that my care was actually very good was even better. I did get a thank you from the woman too – she did say 'thank you very much for being there'. I just felt that that was good; it's just little things like that can just trigger people. Whereas if you're feeling upset or feeling angry, it can make you feel guilty, it can. At the end of the day, I think we just have to think of ourselves as being a support and doing as much as we can but not being the ultimate person who can do it all, when we can't. We have to realise our limitations.	Same midwife, later in interview, returned to the same story (clearly a very important one to her). A real sense of disappointment about the turn of events; saying she didn't feel guilty about it but seems defensive about it. Was she using her manager's praise to prove that she did everything she could have done so she doesn't feel guilty? External validation of her worth? Relieved that the woman has accepted the outcome and is not apportioning any blame. Interference/removing control Giving in Guilt about not doing the 'right' thing Betraying woman's trust?

Appendix Four

Appendix 4

Development of the Codes, Categories and Themes

Stage 1- Free nodes
On initial reviewing of the data in NUDIST, the following 'free nodes' were generated to start to cluster the issues and analyse the data:

Teams	Working with others
Caring	Normal
Abnormal	Not achieving it
Getting what she wants	Control
Special effort	Trust
Communicating	Complaining
Guilt⁻	Friendship
Advice	Checking
Being appreciated	Making a difference
Advocating	Teaching
Giving in	Guiding / support
Confidence	Supporting choice

Stage 2- First Framework
The codes were then grouped in preliminary clusters to start to form categories and themes.

Teams	)	Continuity	)	
Special effort	)			
Making a difference	)	It was special	)	
Caring	)			
Advocating				Building a rapport
Friendship	)	Friendship	)	
Communication	)	Listening	)	
....				
Checking	)	Checking		
Guilt	)	Makes you feel bad	)	Making sure
Not achieving it	)	Feeling let down		
....				
Control	)	Control		
Trust	)	Trust		
Normal	)	No interference		
Getting what she wants	)		)	Playing God
Giving in	)			
Abnormal	)	Interference		
Working with others	)			
....				
Advice	)			
Teaching	)	Knowing what to expect	)	Preparing
Supporting choice	)			
Guiding / support	)			
....				

Stage 3- Second Framework
Some of the codes and categories were integrated or separated as the densification process took place.

Teams	)	Continuity	)	
Getting to know you	)			
Special effort	)			
Caring	)	It was special	)	Making a difference
Making a difference	)			
Advocating	)			
Friendship	)	Building a rapport	)	
Communication	)			

....

Checking	)			
Control	)	Playing God	)	
Trust	)			
Guilt	)	Feeling bad	)	
Not achieving it	)			Making sure
Giving in	)			
Abnormal	)	Interference	)	
Working with others	)			
Normal	)			
Getting what she wants	)	No interference	)	

....

Advice	)			
Teaching	)	Knowing what to expect	)	
				Preparing
Supporting choice	)			
Guiding	)	Help getting there	)	

....

Stage 4- Final Framework
This represents the final stage of codes, categories and themes.

....

Codes		Categories		Themes

....

Relationship	)			
Friendship	)	Building a rapport	)	
Getting to know each other)				Making a difference
It's easier	)	Continuity	)	
Special effort	)	It was special	)	

....

Advice	)			
Teaching	)	Knowing what to expect	)	Preparing

....

Feeling safe/ trust)				
No interference	)	Feeling in control	)	
				Making sure
Guilt	)			
Interference	)	Not feeling in control	)	
Playing God	)			

Appendix Five

On the following pages, there are phrases describing people's behaviours. Please use the rating scale below to describe how accurately each statement describes you. Describe yourself as you generally are now, not as you wish to be in the future. Describe yourself as you honestly see yourself, in relation to other people you know of the same sex as you are, and roughly your same age. So that you can describe yourself in an honest manner, your responses will be kept in absolute confidence. Please read each statement carefully, and then fill in the bubble that corresponds to the number on the scale.

Response Options

1. **Very Inaccurate**
2. **Moderately Inaccurate**
3. **Neither Inaccurate nor Accurate**
4. **Moderately Accurate**
5. **Very Accurate**

Description | | | **Rating Scale** | |

	1	2	3	4	5
Am the life of the party.	O	O	O	O	O
Feel little concern for others.	O	O	O	O	O
Am always prepared.	O	O	O	O	O
Get stressed out easily.	O	O	O	O	O
Have a rich vocabulary.	O	O	O	O	O
Don't talk a lot.	O	O	O	O	O
Am interested in people.	O	O	O	O	O
Leave my belongings around.	O	O	O	O	O
Am relaxed most of the time.	O	O	O	O	O
Have difficulty understanding abstract ideas.	O	O	O	O	O
Feel comfortable around people.	O	O	O	O	O
Insult people.	O	O	O	O	O
Pay attention to details.	O	O	O	O	O
Worry about things.	O	O	O	O	O
Have a vivid imagination.	O	O	O	O	O
Keep in the background.	O	O	O	O	O
Sympathise with other's feelings.	O	O	O	O	O
Make a mess of things.	O	O	O	O	O
Seldom feel blue.	O	O	O	O	O
Am not interested in abstract ideas.	O	O	O	O	O

Start conversations.	O	O	O	O	O
Am not interested in other people's problems.	O	O	O	O	O
Get chores done right away.	O	O	O	O	O
Am easily disturbed.	O	O	O	O	O
Have excellent ideas.	O	O	O	O	O
Have little to say.	O	O	O	O	O
Have a soft heart.	O	O	O	O	O
Often forget to put things back in their proper place.	O	O	O	O	O
Get upset easily.	O	O	O	O	O
Do not have a good imagination.	O	O	O	O	O
Talk to a lot of different people at parties.	O	O	O	O	O
Am not really interested in others.	O	O	O	O	O
Like order.	O	O	O	O	O
Change my mood a lot.	O	O	O	O	O
Am quick to understand things.	O	O	O	O	O
Don't like to draw attention to myself.	O	O	O	O	O
Take time out for others.	O	O	O	O	O
Shirk my duties.	O	O	O	O	O
Have frequent mood swings.	O	O	O	O	O
Use difficult words.	O	O	O	O	O
Don't mind being the centre of attention.	O	O	O	O	O
Feel others' emotions.	O	O	O	O	O
Follow a schedule.	O	O	O	O	O
Get irritated easily.	O	O	O	O	O
Spend time reflecting on things.	O	O	O	O	O
Am quiet around strangers.	O	O	O	O	O
Make people feel at ease.	O	O	O	O	O
Often feel blue.	O	O	O	O	O
Am full of ideas.	O	O	O	O	O

Appendix Six

E   Extraversion

Am the life of the party
Feel comfortable around people
Start conversations
Talk to a lot of different people at parties

Don't mind being the centre of attraction

Don't talk a lot
Keep in the background
Have little to say
Don't like to draw attention to myself
Am quiet around strangers

A   Agreeableness

Am interested in people
Sympathise with others' feelings
Have a soft heart

Take time out for others

Feel others' emotions
Make people feel at ease

Feel little concern for others
Insult people
Am not interested in others ' problems
Am not really interested in others

C   Conscientiousness

Am always prepared
Pay attention to details
Get chores done right away

Like order
Follow a schedule

Leave my belongings around
Make a mess of things
Often forget to put things back in their proper place
Shirk my duties

O   Openness

Have a rich vocabulary

Have a vivid imagination

Have excellent ideas

Am quick to understand things
Spend time reflecting on things
Am full of ideas

Have difficulty understanding abstract ideas
Am not interested in abstract ideas
Do not have a good imagination
Use difficult words

S   Stability

Am relaxed most of the time
Seldom feel blue

Get stressed out easily
Worry about things
Am easily disturbed
Get upset easily
Change my mood a lot
Have frequent mood swings
Get irritated easily
Often feel blue

Appendix Seven

Appendix Seven

Assessing Trustworthiness

Assessment of	Strategy
Credibility (internal validity)	• constant comparative analysis • cross checking of categories • saturation of categories
Confirmability (objectivity)	• personal construct exercise • discussion with supervisors and colleagues • reflective journal
Dependability (reliability)	• description of current position of midwives/ midwifery and its education • cross referencing of participants / data to contemporary situation (reality)
Transferability (external validity)	• presentation of parts or whole of project to many colleagues (fellow research students, practice midwives, midwife educators, students, academic psychologists)