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CLINICAL LEADERSHIP ON THE LABOUR WARD

Julie Carol Parkin

A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements for the degree of Doctor of Philosophy

September 2016

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Abstract

Introduction

Clinical Leadership is a way of facilitating change and increasing the quality of care at the front line of practice. However, the failure of midwifery leadership and being designated an oppressed group questions the ability of midwives to practice as clinical leaders in the labour ward environment. Whilst there is some research relating to clinical leadership in nursing, no research exists that investigates the clinical leadership of midwives who are directly involved in giving care to women.

Aim

The aim of this research was to explore clinical leadership on the labour ward and to develop an understanding of the associated characteristics of clinical leadership. The attributes that delineated effective clinical leadership were examined in addition to associated professional discourses and relationships of power that existed on the labour ward.

Methods

A critical ethnographic approach was undertaken on the labour ward of a district general hospital and a teaching hospital in the North of England, using participant observation and semi-structured interviews. A total of sixty-nine hours of participant observation was undertaken. A purposive sample of 30 midwives were interviewed in the first instance and further interviews were undertaken with 18 midwives who were nominated as effective clinical leaders by the midwives in the initial interviews. Data were examined through the lens of Bourdieu's Theory of Practice.

Findings

Clinical leadership existed at different levels on the labour ward, however, midwives mostly identified LWCs in this role. LWCs' clinical leadership was necessary, contradictory, gendered, socialised and unsupported within the hierarchical, high-risk and fearful labour ward. A combination of heroic and values-based clinical leadership

was required to maintain safety and facilitate productivity. Heroic leadership, the high level of accountability and symbolic capital invested in the LWC led to a loss of autonomy for other midwives, a lack of dissent and difficulty initiating changes in practice. The contradictory nature of the LWCs' work and a lack of support led to them experiencing both emotional and physical stress. Within an increasingly high-risk labour ward environment the LWC clinical leaders experienced professional misrecognition and discrimination that resulted in dysfunctional inter-professional relationships and keeping the obstetricians away from women.

Conclusion

A high level of responsibility invested in the LWC combined with socialisation led to heroic leadership which fostered dependency prevented change and innovation. Inequalities of power and dysfunctional relationships were symptoms of a system failure that does not support midwifery practice or woman-centred care. Recommendations are made for policy, education, practice and future research.

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Word Count: 80,320 words / - references and appendices.

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Acknowledgements

There are many people I would like to thank. Without their help, encouragement and advice, the undertaking and writing up of this study would not have been possible. My appreciation goes out to the midwives on the labour wards of Northvalley and Springdale, for their welcome, time and frankness whilst collecting the data. My thanks is extended to my supervisors Dr Joyce Marshall, Professor Ruth Deery and Dr Pamela Fisher for their wisdom, support and critical friendship. I acknowledge Kirsty Thomson, for her understanding of and guidance through the process and the research and development departments at both hospital trusts for their direction and assistance. I am grateful to my work colleagues for facilitating the time and space I needed whilst writing up. Thanks to my family and friends for their understanding, when as Mum, Daughter, Grandmother, Sister and friend I have forgone their company for that of my study and computer. Finally, I owe a debt of gratitude to my lovely husband David. Without his steadfast support, expert culinary skills and love of golf I would not have completed my task.

Glossary of Terms

‘Acting’ Band 7 midwife	An ‘Acting’ Band 7 midwife is a Band 6 midwife who has applied to undertake the Band 7 LWC job (‘act up’) for a period of time (the higher pay band is awarded during this time) as a means of developing leadership skills and being supported by the LWCs in post.
Anaesthetist	Anaesthetists are doctors who are responsible for pain relief and administering anaesthetics during surgery.
Birth Centre	Birth Centres are places where women at low risk of complication can access to give birth and are cared for by midwives only.
Breaking the waters or artificial rupture of the membranes (ARM)	Breaking of the waters or ARM refers to a procedure that involves inserting an instrument through the neck of the womb when open to rupture the bag of water that surrounds the baby as a means of stimulating contractions. Routine use of ARM is not recommended as it can cause infection and cause the baby’s heart to become abnormal. This can lead to a cascade of medical intervention that may harm both the woman and baby.
Breech birth	Breech birth occurs when the baby’s buttocks are born first. It is associated with increased mortality and morbidity for the mother and baby, however, there is an expectation that a midwife knows how to facilitate this type of birth.
‘Burn out’	A physical and psychological condition associated with fatigue and stress.
Caesarean section	A Caesarean section is the surgical removal of a baby via the mother’s abdomen. Whilst in certain circumstances the procedure can be life saving for both the mother and the baby it is now well documented that there are many unnecessary caesarean sections performed and they are also associated with severe complications for both mother and baby, such as breathing difficulty, bleeding and infection.
Cardiotocograph trace (CTG)	Cardiotocograph tracing refers to the electronic recording of the fetal heart rate.
Cascade of intervention	A cascade of intervention refers to the phenomenon that one intervention leads to another intervention.
Cervical dilatation	Cervical dilatation refers to the opening of the neck of the womb measured in centimetres that facilitates the birth of the baby. The neck of the womb (cervix) opens up from zero centimetres to ten centimetres.
Collaborative Leadership	Collaborative in that leaders are able to cross boundaries and work together
Community Midwifery Team Leaders	Midwifery team leader roles exist in community midwifery teams and in hospital teams and tend to have a managerial role as part of their remit.
Co-morbidities	Co-morbidities are conditions, such as obesity, heart disease or diabetes that may negatively impact on the health of women and subsequently affect their health and that of their baby in pregnancy and during and after birth.
Connective leadership	Connective leadership where there is collaboration and interactive persuasion
Consultant Midwife	Consultant Midwives’ roles are not managerial but expert practitioners who develop professional leadership and consultancy and develop practice.
Consultant Obstetrician	The consultant obstetrician is the most senior doctor caring for pregnant women at high risk of complication.
Continuity of care(r)	Continuity of care/ carer refers to the practice of having one midwife to care for the woman throughout pregnancy and labour and is associated with increased satisfaction with care for both the woman and the midwife.
Delivery of the placenta and delay	The placenta is expelled following the birth of the baby, however there may be a delay with this that can involve the use of different manoeuvres to facilitate its’ release to prevent the mother bleeding excessively.

Democratic Leadership	Democratic suggests that leadership is distributed fairly and proportionately within a service.
Direct care	Direct care suggests the act of physically caring for a person. It is 'hands on'.
Distributive Leadership	Distributive leadership refers to distributing the pattern of leadership amongst the workforce in organisations to facilitate the participation of employees so that their voices are heard.
District General Hospital	District general hospitals provide basic local services to the people in the surrounding area.
Domestic	A domestic is an old term for a person who works on hospital wards as a cleaner
Early labour and early labour services	Early labour is the beginning of labour when contractions and progress are not well established. Early labour services are an important component in women's experiences of childbearing. They consist of meetings with women either at home or hospital to help to determine the onset of labour and prevent unnecessary admission to hospital and early intervention. These services can be a form of support and reassurance for women that is highly valued by them.
Eating in Labour	Offering food to women in labour gives them the energy required to birth their baby rather than giving drugs to stimulate contractions.
Emotion Work	Emotion work refers to the emotions involved in carrying out one's work with others. It can be positive or negative.
Epidural analgesia	Epidural analgesia is an invasive form of pain relief that is administered via a small tube into the epidural space in the mother's spine by an anaesthetist. Whilst it is the most effective type of pain relief it reduces the woman's ability to be mobile and may prolong the time that it takes to push the baby out.
Episiotomy	Episiotomy is an incision made to widen the mother's external tissues that may hasten the birth of the baby's head.
Established labour	Established labour refers to the time that a woman is determined to be in labour proper (rather than early labour) and when time parameters are established to determine the length of labour.
External cephalic version (ECV)	ECV is the process of turning the baby from a bottom down (breech) position in the womb, to a head down (cephalic) position via the mother's abdomen which results in the prevention of caesarean section.
Fetus	The fetus is the name given to the baby until it is born.
First examination of the newborn baby	An examination of the baby's condition, including listening to the heart to rule out any abnormalities heart.
Front line care	Front line care is the care that is given directly to clients.
'Fully dilated'	Being fully dilated refers to the cervix (neck of the womb) being opened to its' fullest extent that is necessary for the baby to be born.
Gynaecology	Gynaecology is a medical speciality that cares for women with diseases of the female reproductive system.
Haematologist	Haematologists are doctors who are responsible for providing blood and blood products and testing of blood.
Health Care Assistant (HCA)	Health care assistants are not qualified health professionals but assist midwives in their day to day work.
High risk pregnant women	High risk women are women, such as those giving birth to twins or women with medical conditions, such as high blood pressure or diabetes, who may have required medical assistance.
Head of Midwifery	The Head of Midwifery has strategic responsibility for the maternity services under her jurisdiction and to oversee any research within them.
Horizontal violence	'Horizontal violence' describes a form of conflict within a group that represents an understanding of how those groups who experience oppression express their irritations towards each other as a reaction to an organisation that has rendered them powerless.

'In charge' of the labour ward	The midwife in charge was the person responsible for the coordination of activity on labour ward on a particular shift.
Induction of labour	Induction of labour is an intervention at the end of pregnancy, performed as a means of reducing the rate of stillbirths. However its use is utilitarian to prevent a few deaths and is also associated with increased intervention and potential morbidity for the woman
Instrumental birth	The application of instruments to the baby's head, such as forceps to accelerate the birth of babies who may be compromised at birth.
Maternity Unit	Maternity unit represents all the maternity services provided in a hospital.
Medical intervention	Early and unnecessary medical intervention is associated with the potential to harm women and babies.
Mobility in labour	Being mobile in labour enhances the regularity of contractions and widens the pelvis and may facilitate vaginal birth.
Labour Ward	The labour ward is an area within hospital maternity services where women are able to go to give birth to their babies. Hospital labour wards are also where women deemed to be at high risk of complications in pregnancy and labour are advised to give birth to their babies so that they are able to access the obstetrician if complications occur. It is sometimes referred to as labour suite or delivery suite There are other places women can give birth, such as at home or birth centres if their pregnancies are not complicated.
Labour Ward Coordinator (LWC)	Labour ward coordinators may also be referred to as shift leaders who are responsible for the practice on each shift they work and have usually some degree of management responsibility attached to their role.
Lead Midwife for Education (LME)	The LME position is a leadership role in Higher Education Institutions (HEIs) to support and develop midwifery education.
Leading an Empowered Organisation (LEO) course	LEO is a three day course run by the National Health Service (NHS).
Length of labour	How long labour lasts from becoming established to the delivery of the baby and placenta and the control of bleeding. Over the past 50 years the length of labour has been reduced drastically due to medical acceleration and the practice of starting labours artificially and does not reflect the length that some women may need to birth their babies. This has led to a rise in caesarean section and increased morbidity for women and their babies that cannot be rationalised.
Low risk pregnant women Matron	Low risk women are those pregnant women at low risk of complications that do not require medical intervention. The Matron in midwifery is usually responsible for a certain area, such as community services or hospital services, for cleanliness and instigating trust policy. She /he is not involved in giving direct care to women. The matron's position is towards the top of the hierarchy in midwifery.
Medical model of care	A medical model of care reflects a view that pregnancy and birth is risky and concentrates upon the management of physical symptoms.
Medical ward	Medical wards are hospital wards where people who have medical conditions, such as heart or lung disease that require medicinal treatment rather than surgical intervention.
Midwifery Lecturer	Midwifery lecturers are employed and work in universities to prepare student midwives to become midwives.
Multigravida	Multigravida refers to a woman who has given birth to a baby previously.
Newly qualified midwives	Newly qualified midwives are those midwives who have just entered the midwifery register who have not yet had much experience and who require support from the LWC.
NHS Trusts	The health service in the United Kingdom is divided into different areas named Trusts' that are responsible for the services within a particular geographical area.

Normal midwifery	Relating to care that facilitates biophysical processes and infers a belief in women's capability to give birth.
Normalising care	Normalising care refers to facilitating pregnancy, labour and birth without intervention. To facilitate physiological processes.
Nursing and Midwifery Council (NMC)	The NMC is the organisation that professionally regulates midwives, health visitors and nurses in the UK.
Nutrition in labour	Eating in labour supports the woman's energy requirements for effective labour contractions.
NMC Code	The Code reflects the duties and responsibilities of nurses, midwives and health visitors in the United Kingdom who are on the register of the Nursing and Midwifery Council.
Obstetrician	Obstetricians are doctors responsible for the care of pregnant women at high risk of complications in pregnancy and birth.
Obstetric	Obstetric relates to the doctors responsible for complex care in the maternity services
Obstetric Registrar	The obstetric registrar is the senior doctor caring for pregnant women at risk of complication who is responsible only to the consultant obstetrician.
Operating Department Practitioner (ODP) Paediatrician	ODPs are clinicians who assist the anaesthetist during surgical procedures. Paediatricians are doctors who are responsible for the care of sick babies and children. A paediatrician would usually be called to attend the birth of a baby that was it was anticipated would have some difficulty breathing.
Pay Bands	Pay band refers to the pay scale that determines the salary that midwives receive. Historically individual midwives in the maternity services have been recognised by rank and nursing related titles: staff midwife, junior sister and senior sister. From the mid - 1980s rank was determined by pay scale, grades E, F, G and H and more recently pay bands. The pay banding runs from Band 5 that represents newly qualified midwives with little clinical experience in midwifery through to Band 6, 7 and 8. Whilst the higher the band suggests the possession of more clinical experience and knowledge, those midwives practising at Band 6 may have been qualified as midwives a long time but have not applied for promotion to a higher band. The pay within each banding is incremental. Band 7 midwives have a managerial aspect attached to their role but are clinically based on the labour ward. The Band 8 midwives are either midwifery matrons or consultant midwives who generally have a strategic or educational role in the local maternity service.
Perineal Suturing	The repair of trauma to the woman's genital area following birth.
pH	pH refers to a procedure to take blood from the fetus whilst the woman is in labour to test the acidity of its blood which can reveal whether the fetus is distressed and needs to be born immediately or not. It is usual to assess the acidity of the fetus' blood prior to going to theatre to perform a caesarean section as it may be a more accurate indicator of well- being than CTG tracing.
Pharmacist	Pharmacists are clinicians who dispense drugs.
Physiotherapist	Physiotherapists are clinicians who help to restore movement and function after illness or assist in clearing the lungs and airways.
Porters	Porters are ancillary staff who transport people and objects around the hospital.
Position change in labour	Changing the woman's position may speed up a woman's labour by increasing the diameters of her pelvis to more easily let the baby escape.
Postnatal	Postnatal refers to the period following the birth of the baby.
Pre eclampsia	Pre- eclampsia or being pre-eclamptic refers to a condition prior to eclampsia when a pregnant woman has a seizure. Pre eclampsia is associated with a raised blood pressure and failure of the major organs in the body, such as the kidney and the liver.
Professional Dissonance	Professional dissonance is a disjuncture between espoused values and the reality of practice.
Retained Placenta	Retained placenta is when the afterbirth/placenta is not delivered following the birth of the baby and often requires removal under a general anaesthetic in theatre.

Royal College of Midwives (RCM)	The RCM is a professional trade union that supports midwives.
Scrub in theatre	To scrub in theatre is to prepare the surgical instruments in theatre and assist a doctor with operations- usually caesarean section.
Second stage of labour and delay	The second stage of labour is when the baby is pushed out of the vagina by the mother. Delay in the second stage can result in morbidity for the mother or the baby and may lead to medical intervention to expedite the birth.
Senior clinician	'Senior' clinicians hold positions at a higher level in the hierarchy and receiving more pay.
Shift	Midwives work 'shifts' that consist of a prescribed number of hours, such as 12 hours.
Shoulder dystocia	Shoulder dystocia is a recognised emergency in childbirth where a shoulder of the baby becomes trapped following the birth of the baby's head. Failure or delay in releasing the baby's shoulder may lead to the death or neurological damage of the baby.
Skill mix	Skill mix relates to having a number of midwives working on a shift that have a variety of skills to facilitate giving care effectively to women.
Social model of care	A social model of care addresses the woman's social circumstances and relationships as well as her physical symptoms.
Specialist nurse/midwife	A nurse or midwife who has advanced skills in a specific area of practice.
Spontaneous vaginal birth	Spontaneous vaginal birth refers to a birth that starts without intervention and proceeds to the baby being born through the effort of the mother.
Supervisor of Midwives	All midwives are currently required through statutory regulation to be supported by a Supervisor of Midwives (SOM). The SOM provides support and guidance to midwives in order to protect the public from sub-standard care.
Syntocinon drip	A Syntocinon drip is the drug Syntocinon that is given via a woman's vein to stimulate labour contractions
Team Leader	Team leaders may have some minor managerial responsibilities but are responsible for the shifts they work and are closer to practice dealing with the facilitation of day to day clinical care giving.
Tear (to the perineum)	A tear is trauma to the woman's genitalia following birth that may require suturing to repair the tear.
Tertiary Hospital	Tertiary, teaching hospitals provide more specialised services and although they serve the local population they also receive women/clients from other areas who require specialist care.
Theatre Coordinator	These nurses practice in operating theatres where medical operations take place and who coordinate the activity.
Theatre scrubs	Scrubs are the clothes that are worn in operating theatres.
Trial of instrumental birth	Trial of instrumental birth refers to the practice of taking a woman to an operating theatre who requires the use of instruments, such as forceps or ventouse to facilitate the birth of her baby and if it is unsuccessful a caesarean section will then be quickly performed. Hence the term trial as it suggests the use of instruments may not be successful.
Vaginal birth following caesarean section (VBAC)	VBAC refers to the normal birth of a baby following a previous caesarean section. The literature suggests that for most women who have had a previous caesarean section vaginal birth is successful as long as there are no contraindications to having a birth vaginally.
Virtuous circle	Is a structure where the results of one effective behaviour feeds back positively to produce circumstances for more effective behaviour.
Ward Clerk	The ward clerk is someone who is responsible for answering the telephone, opening the labour ward entrance, accessing clinical records and other administrative duties.
Ward Manager	Hospital wards usually have a ward manager who has overall responsibility for the area. The ward manager is responsible for ensuring staffing and resources are adequate, appraisal of staff, support and facilitating their development etc.

Ward round

Ward Sister/Charge Nurse

White Board

A ward round is a visit paid to a ward area by a senior doctor who is escorted, usually by a senior midwife or nurse to see each client.

The ward sister is the female term for the health professional who has managerial responsibility for a particular clinical area. The charge nurse is the male derivation of the ward sister.

The whiteboard is where details of the women who have been admitted to labour ward are written so that it can be seen at a glance, which women are present, whether they are in labour or not; what progress has been made in labour; how many babies they have given birth to previously and whether any complications in their pregnancy or labour exists.

CHAPTER ONE: INTRODUCTION AND BACKGROUND

Introduction

This thesis explores the nature of clinical leadership on the labour ward within the United Kingdom (UK) context, in particular England, with regard to the inequalities and power relationships that exist. It critically examines the characteristics of the midwives perceived to be clinical leaders on the labour ward and the professional discourse associated with their clinical leadership practice to gain an insight into their experiences and impact.

Leadership is perceived to be an important component in organisations as it has the potential to influence change and contribute to the smooth running of organisations (Bass, 2008). More recently, clinical leadership is espoused within the National Health Service (NHS) as a means of directly enhancing the quality and reducing the cost of care for those who are in receipt of it (The King's Fund, 2011, 2012, 2013, 2014a, 2014b, 2015). Clinical leadership may therefore be valuable within the labour ward. This chapter will explain the reasons for choosing clinical leadership on the labour ward as a subject for this study and the clinical experience that impacted upon the choices that I made at the outset. It will also briefly discuss the background reading that informed my decision making.

Setting the Scene

Consideration of the historical and cultural development of midwifery in England is important to this study as it offers an explanation of the current context within which midwives practise. The development of midwifery has been influenced by societal changes, professionalization and issues of class, gender and power. This introduction will provide a brief overview of midwifery's development. For a more

comprehensive insight see Donnison, 1998, Leap and Hunter, 1993, Borsay and Hunter, 2012.

Until the seventeenth century midwives were self-employed women who were responsible for the care women received during the childbirth continuum and dealt with both normal and complex situations (King, 2012). These midwives were autonomous, local, handy women who learned their skills over time as apprentices and who were valued by the women in their communities (Nuttall, 2012). However, the seventeenth and eighteenth centuries witnessed a period of enlightenment, an interest in science and the increasing involvement of men in midwifery, especially related to emergency care. These developments led to the demise of the 'handy woman' who began to be eyed with suspicion (Leap & Hunter, 1993 p.10). Being cared for by male midwives (who were to become obstetricians in the twentieth century) became fashionable with the upper classes and scientific knowledge started, and continued, to become more authoritative than that based upon extensive practical experience (King, 2012). Jordan (1997, p. 57) comments that the men midwives accrued 'cultural authority' that became naturalised and therefore accepted as truth, whereas alternative sources of knowledge were deemed to be unenlightened. The lower social class origins of the handy women and their status as women at the time impeded their resistance (Donnison, 1988). However, Hunter (2012) states that over the last eighty years midwives have not voiced their concerns and that no consensus exists as to the way forward for the profession.

The nineteenth and early twentieth century saw the struggle for the control of childbirth, not only between midwives and the medical men but between working class and educated midwives (McIntosh, 2012). Educated, middle-class women during the first wave of feminism, through the Midwives' Institute, referred to by Heagerty (1996, p.13) as the 'aristocracy of midwives', sought to make midwifery a respectable profession for themselves through regulation and education. The

passing of the Midwives Act 1902 in England fulfilled the Midwifery Institutes wishes and resulted in the restriction of midwifery practice to only those midwives who were certified to do so, were of good character and who held the relevant qualifications. Many of the local handy women who continued to practice locally were often unable to afford or have the educational background to meet the requirements of registration (Heagerty, 1996). The Central Midwives Board (CMB) was created through the Act to hold a register of midwives, define midwifery rules and operationalise the supervision of midwives by medical practitioners. Heagerty (1996) submits that the professionalization of midwives removed them from their traditional working class roots and women to become remote and allied to the medical profession. Mander and Reid (2002) suggest that the Act realised the subjugation of midwifery by medicine.

The move of birth from home to hospital that started with the lying-in hospitals in the early 1800s (King, 2012), increased with the formation of the NHS in 1948 and continued into the 1970s led to the transformation of midwifery practice. The move to hospital was primarily seen as a means of providing women with access to clean conditions, food and antenatal care as a means of attending to public health concerns (Donnison, 1988). However, during the 1950s, 60s and 70s safety drove the increasing hospitalisation of birth, despite a lack of evidence to support it (Tew, 1990). The increasing technological advances, such as epidural analgesia and the normalisation of hospital birth led to the rise in the concepts of safety and risk and the polarisation of midwifery and obstetric philosophies (Kirkham, 1983). However, the second wave of feminism in the 1960s and 1970s railed against the medicalization of childbirth and the routine use of medical intervention (Hunter, 2012). Independent midwifery also experienced a resurgence (Hunter, 2012). Women's voices were heard and eventually led to the Changing Childbirth Report (DoH, 1993) that advocated choice, continuity of care and control for women and the sharing of

power between women, midwives and obstetricians. However, Mander and Reid (2002, p.16) state that the promise of changing childbirth (DOH 1993) has not become reality and the feasibility of power-sharing is 'less than realistic'. Currently the majority of midwives providing care for women during birth practise within the confines of a bureaucratic, technocratic, hierarchical NHS built upon male, medical values and have no experience of working closely with women in a social model of midwifery.

My interest in leadership on the labour ward stems from my own experience as a midwife practising on a labour ward in the 1980s through to the early 2000s. Whilst this is some time ago and may not reflect current practice, my continued involvement in care as a supervisor of midwives and midwifery lecturer suggests my experience is representative of what currently exists. During the latter part of my clinical career I practised as a senior¹ midwife on a hospital labour ward: a leadership position that is currently referred to as a 'Labour Ward Coordinator' (LWC) or 'Shift Leader' or 'Band 7' midwife. Throughout the thesis this position will be referred to as LWC to avoid confusion.

In the UK NHS the LWC coordinates the care of women and is responsible for the clinical activity on labour ward during each shift. She/he liaises with a variety of other people, such as midwives, women and their families, obstetricians, paediatricians, anaesthetists, nurses, operating department practitioners (ODPs), pharmacists, physiotherapists, health care assistants, cleaners and porters, all of whom work closely together and are vital to the practice environment to facilitate its smooth running.

¹ By senior I suggest that I was paid on the highest clinical grade in practice and had a great deal of clinical experience and knowledge.

I became aware anecdotally of how instrumental the LWC appeared to be with regard to the decisions made concerning the care that women received. The LWCs who possessed a medical view of care, that suggests birth is risky, more readily deferred to the obstetrician. The LWCs' deferral to the obstetrician, rather than listening to other midwives or the woman and her family, had the potential to lead to a cascade of further medical interventions (Walsh, 2007). This behaviour was out with my own view of what leadership in clinical practice should be. My own view is that:

'A clinical leader in midwifery is a clinically credible midwife who has up-to-date knowledge, is able to guide and empower other midwives to positively influence appropriate midwifery care and who advocates for women'.

Other LWCs with whom I practised employed midwifery knowledge and values to promote normal birth in a number of ways. These LWCs facilitated the time required for individual women to birth their babies in the absence of other complications. Rather than being tied to strict time parameters and resorting to more medical, interventionist means of enhancing labour the LWCs encouraged midwives to employ midwifery strategies to stimulate the progress of labour, such as helping women to adopt different positions and offering them food. This approach facilitated the development of midwifery skills and the empowerment of women wanting to experience normal vaginal birth. I acknowledge there is some debate as to what normal birth is (Odent, 2008, Royal College of Midwives (RCM), 2004, Beech, 1997): whether normal suggests vaginal birth experience that is 'usually' experienced by women that currently involves some medical intervention or birth without any intervention. I am aware that should I refer to 'normal' birth being free of any intervention, it may imply that birth associated with medical intervention is 'abnormal', however, this is not my intention. I refer to 'normal' birth as the birth without intervention that is reflected in the midwifery discourse that midwives espouse (Nursing and Midwifery Council (NMC), 2012).

The manner in which the LWCs practised also appeared to impact the labour ward environment. The LWCs were able to either, empower and develop midwives to make their own decisions in collaboration with themselves or, alternatively, prevent this by being authoritarian and overruling their decisions. The LWC's mood and personality impacted on the mood and morale of the other staff on the labour ward: they either created a happy working environment or one in which the mood was low and less enjoyable. My experience suggests that leadership on labour ward is important with regard to the care women receive and to the well-being of midwives, and therefore worthy of investigation.

The Literature

There is an enormous amount of literature available with regard to leadership. At the start of my research journey I began by exploring the development, diverse styles and theories of leadership to facilitate my understanding of the concept. Broad searches of a large number of databases and books were undertaken using few parameters that resulted in the reading of a wide range of perspectives on the subject. Before I embarked on this research I anticipated exploring leadership in midwifery. However, whilst reading the leadership literature the concept of 'clinical leadership', that related to leadership aligned closely to the bed-side and client care, most clearly represented the type of leadership that occurred on the labour ward, on the front line of practice. I eventually narrowed the searches to retrieve the leadership and clinical leadership literature that was relevant to the National Health Service (NHS), midwifery and the labour ward. Whilst, I was aware of the hierarchy in the NHS, I had not considered the potential impact of power relationships upon leadership and midwifery practice until I commenced my preparatory reading. However, the realisation led to the eventual formulation of the research objectives.

Aim and Objectives

The overarching aim of this research was to explore clinical leadership on the labour ward. The objectives were to:

- Critically explore clinical leadership on the labour ward in relation to power and professional discourses.
- Critically examine the characteristics attributed to clinical leadership.
- Critically explore the characteristics attributed to those clinicians identified as effective clinical leaders on the labour ward.
- Critically examine the experience of being a clinical leader on the labour ward

Outline of thesis

Chapter two of the thesis provides a background to the development of leadership over the past 60 years. It discusses the development of leadership in the NHS and in midwifery and introduces midwifery and labour ward culture. The chapter concludes by discussing the empirical literature associated with midwifery leadership. In chapter three the concept of 'clinical' leadership and the current rise in interest surrounding it is discussed. The literature with regard to clinical leadership in midwifery and nursing is critically considered to determine what is already known about the subject.

Chapter four explores the critical ethnographic methodology and describes the methods employed to meet the aim and objectives of the study. The manner in which the data were generated is presented and an explanation of the use of Bourdieu's Theory of Practice (Bourdieu, 2013) as a means of analysing a critical ethnography is given.

In chapters five, six and seven the two main themes of 'safety' and 'identity' in the findings are presented and discussed in light of the current literature and through the lens of Bourdieu's Theory of Practice. The identity of the clinicians perceived to be

clinical leaders is presented in chapter five. Chapter six is in two parts. Part one examines the impact of the unsafe labour ward on the clinical leader. In part two the clinical leader characteristics and the practices that develop to deal with such an environment are examined. Chapter seven then explores the impact of the clinical leader on other midwives and the impact on midwifery identity per se of a labour ward in flux.

Chapter eight discusses the findings and explores the strengths and limitations of the research. Chapter nine concludes the thesis by presenting the recommendations of the research for clinical practice, education, policy and future research in this area. A proposal for the dissemination of the work is outlined and conclusion drawn.

CHAPTER TWO: LEADERSHIP

'No phenomenon of social life is more discussed, more controversial and less understood than the concept of leadership'

(Vinzant & Crothers, 1998, p. 72)

Introduction

This chapter will explore the development of leadership to provide a background for and to rationalise the growth of leadership as a concept in the National Health Service (NHS). The apparent importance of leadership in society, various leadership theories and styles and the drive to advance leadership in the NHS will also be discussed. The literature pertaining to midwifery leadership, midwifery culture, the labour ward and the empirical work associated with midwifery leadership will be critically discussed as a prelude to the examination of clinical leadership, an emerging style of leadership and the subject of the research.

Leadership

Effective leadership has been defined by Bass (2008) as:

'The interaction among members of a group that initiates and maintains improved expectations, and the competence of the group to solve problems or to attain goals'.

(Bass, 2008, p. 26)

Leadership is recognised as being important as it is seen to influence human performance and facilitate change. Bass (2008) suggests that there are no known societies that do not have leadership in certain parts of their social lives and it is frequently regarded to be the distinct and most critical factor that determines whether institutions succeed or fail. Gemmill and Oakley (1992), Barker (2001), Alvesson and Sveningsson (2003) and Brown (2015), however, suggest that the social concept of leadership is a myth that sustains a belief in the requirement for

hierarchies. The importance leadership assumes may be responsible for the plethora of literature currently available on the subject which appears to centre on discovering what makes an effective leader (Collinson, 2005). Researchers have attempted to discover what leadership is for over sixty years, however, the results have been inconclusive and inconsistent, and led to much confusion (Alimo-Metcalfe & Alban-Metcalfe, 2006, Collinson, 2005, Ford, 2006, Alvesson & Sveningsson, 2003). Barker (2001) suggests that leadership is a conventional idea, rather than something more tangible, that is, we understand what leadership is until we come to define it. Leadership therefore remains a concept that is difficult to explain (Howieson & Thiagarajah, 2011) and that is not well defined (Stodgill, 1974, Barker, 2001, Bolden, 2004, Northouse 2016); the inner workings and particular dimensions cannot be clearly spelt out.

Leadership Theories

Classic modernist leadership theories have developed through 'ways of viewing the world that emphasise control, competition, power and rationality' (Barker, 1994, p. 82). Whilst I acknowledge that leadership theories are important and will explore some of them, it is not within the remit or scope of the thesis to address all of them in detail (for further insight see Bass, 2008 and Northouse, 2016). Much of the leadership literature is American and espouses a masculine, charismatic, individualistic leader: stresses the responsibilities of followers rather than their rights and assumes a hedonistic rather than altruistic motivation to lead (Collinson, 2005, House & Adyita, 1997). Pringle's (1988) research on female-led workplaces, however, suggests that women also engage in antagonistic, sexualised, contradictory cultures to resist control and, women with masculine traits defined as aggressiveness, assertiveness, and confidence, who are also able to monitor their behaviour and fit into their environment may be more likely to receive promotions (O'Neill & O'Reilly, 2011). The assimilation of masculine behaviour by women may

be the only alternative to enhance women's power in a patriarchal society. Concern has also been raised regarding the application of studies that are based mainly on the observation of top managers in organisations (Bryman, 1996). Until the 1990s research samples from which models of leadership were developed did not represent women's views equally as few women held senior positions in large organisations (Alimo-Metcalfe & Alban-Metcalfe, 2005) nor did they include representation from black or ethnic minorities. Tourish (2013, p.4) suggests macho imagery of leadership is rife. Gender differences do exist, and women are more likely to see leadership and perceive their own leadership style to be transformational and men, transactional (Alban-Metcalfe, 1995, Sparrow & Rigg, 1993). This is important in midwifery and nursing which are predominantly female occupations. Leadership models based upon American, predominantly white, male, white collar workers may not facilitate organisational leadership that reflects the diversity of either the employees or the communities they serve.

There are several leadership theories, such as the biological, genetic, Great Man (born to lead, strong, heroic warrior leader) and Trait that suggest people who become leaders have particular characteristics that cannot be learnt and focus on dominant high status leadership (see Appendix 1 for further information regarding leadership theories). However, Brown (2015, p. 374) suggests that a culture of strong leaders may be 'dangerous' in either dictatorships or democracies as it concentrates a great deal of power in one person's hands. Ford (2006, p.5) also suggests that 'through the reification of leadership the concept of leadership takes on an objective existence that seems to make it beyond challenge'. The focus on the importance of leadership traits does not appear to have facilitated leadership development and the context and environment within which leaders operate is often ignored in the research literature (Ford, 2006). The environment within which leaders operate has significant influence upon the manner in which they exercise the role and is context specific.

Alvesson (2002) posits that to understand cultural leadership an understanding of what leadership means locally is required, as for diverse groups it may have different associations.

Management and Leadership

Until the late 1970s leadership theory was concerned with transactional leadership that is related to management and has its' emphasis on leaders and followers. Leadership and management were perceived to be interchangeable terms. However, Millward and Bryan (2005) suggest they are different: management being concerned with planning, organisation and control, whereas, leadership is a process of influence. Management is perceived to be different to leadership as managers have people who work for them (and therefore organise and coordinate), whilst leaders have followers (who they inspire and motivate).

More recently the term manager has been associated negatively with bureaucracy and doing things right and leadership more positively with motivating change and doing the right thing (Bennis, 2009, Drucker, 2001). Although the Health Foundation's position statement on effective leadership (Anderson, Malby, Mervyn & Thorpe, 2009) suggests that leadership, as a concept, has replaced management, some aspects of transactional leadership, such as the qualities for managing bureaucracy may be necessary in large organisations. Transactional leadership may also be enhanced by the possession of transformational leadership qualities (Alimo-Metcalfe, Alban-Metcalfe, Samele, Bradley & Mariathasan, 2007). Martin and Learmonth (2010) suggest that historically the NHS moved from administration to management to rebrand what are basically similar activities. The move from management to leadership may also be motivated, in part, by making something old seem new. Gosling and Murphy (2004) suggest that leadership and management are fundamental parts of the same job: good management may be enhanced rather than

replaced by leadership and effective management skills may be required to implement and sustain change.

Leadership, Followership and Power

Leadership has been perceived to be a transactional process through which many people are organised to move in a specified direction, by a visionary, charismatic, distant leader who is seen as the person most responsible for an organisation's actions. Bass (2008) suggests action involves the leader giving direction to a subordinate or discussing the requirements to reach the organisational objectives and engagement with the leader does not extend beyond this. Leadership is, however, also seen as a social process, involving complex, reciprocal relationships. Gemmill and Oakley (1992, p.124) define leadership as a 'process of dynamic collaboration' and Barker (2001, p. 491) states:

'A function of individual wills and of individual needs and the result of the dynamics of collective will, organised to meet those various needs.'

Samuels (2001) suggests that the word power cannot be avoided in relation to leadership, whether it is benevolent or malevolent. Followership, along with leadership, is perceived to be important and possessing power, as ultimately followers support and give authority to leaders. Kelly (1992) suggests that whilst leadership is perceived to be important, it contributes no more than twenty percent to the success of the team. Followers therefore contribute eighty percent to any success (Coombs, 2014). However, leadership has been perceived to be authoritarian and related to control of interactive processes. Leaders enable followers to undertake their role and bring clarity and a sense of security to followers that secures their support (Stech, 2004). Authoritarian leadership may be more common in mechanistic, bureaucratic organisations that are bound by rules and following protocols (Bass, 1985) and alongside heroic leadership, may exclude large numbers

of people in organisations from power. Organisational leaders that decide what to do whilst the others follow, may lead to an emotionally de-skilled, dependent work force with a desire for an omnipotent leader to which they are able to devolve their responsibility (Gemmill & Oakley, 1992 and Alvesson & Sveningsson, 2003). Being able to devolve responsibility is increasingly relevant in a more risk averse and litigious workplace where the fear of risk and blame is high. However, it may deter questioning and prevent learning that can facilitate innovative working.

Gronn (2008) is critical of the theories related to the privileged position of the leader in the relationship between leader-follower and advocates the importance of distributive leadership that implies interdependence and reciprocal influence. It appears naïve to consider that subordinates or followers have no influence in organisations. Meindl (1995) suggests the romantic, exaggerated vision of the capabilities of leaders provides a superficial way of understanding complicated organisational processes and that there is a propensity to overstate the contribution leaders make to organisational success. Alimo-Metcalfe and Alban-Metcalfe (2005) are also concerned that the simplicity of the notions of leadership may not be relevant for the highly politicised public sector and for employees, such as teachers and nurses who practice under challenging circumstances.

The favoured approach to the study of leadership has been laboratory-based experiments and questionnaires that have largely excluded contextually specific qualitative studies that may enhance the practical application of findings (Yammarino & Dubisnky, 1990, Alvolio, Bass & Jung, 1999, Bliese Halverson, 2002). Ford (2006) suggests that a social and local definition of leadership may facilitate an understanding of the meanings that the community being studied attribute to leadership, and facilitate its development.

Post Heroic Leadership

Alimo Metcalfe and Alban Metcalfe (2005) suggest that since the 1970s a new approach to studying leadership has emerged that arose from the massive changes that occurred during the economic recession and the dissatisfaction with the models of leadership that only balanced concern with task and production that was seen as management rather than leadership. Currently a post heroic, distributed form of leadership is being espoused to encourage employees in large organisations to deal with the constant change and see themselves as informal leaders that enhances their practice and gives them a sense of responsibility within their organisation (Holmes, 2011).

Transformational Leadership

Transformational leadership represents a seminal shift in the field of leadership and has been named the 'New Paradigm' (Alimo-Metcalfe & Alban Metcalfe, 2005 p. 54). Transformational leaders are capable of inspiring their followers to modify what they believe and anticipate, and to pursue common goals through the potency of the leaders' vision and personality (Burns, 1978). Transformational leadership places emphasis on the importance of followership, enabling and legitimising leadership, as well as more ethical, transparent, authentic leadership (Burns, 1978) which is unsurprising given the recent growth of corporate governance. This avoids the danger of a potentially self-serving leader who takes responsibility for the success of their organisation and punishes those who are critical. Some of the failure of large corporations has been attributed to the unchecked arrogance of their top executives (Tourish, 2013), such as the Chief Executive Officer at the Royal Bank of Scotland, which led to disquiet with regard to the dominance of visionary, charismatic, heroic leadership during the last twenty years of the twentieth century. Tourish (2013) suggests that bankers have come to symbolise much of what is currently wrong with leadership.

Byrom, Byrom and Downe (2011) suggest that there are similarities between the leadership literature's move away from hierarchical models to those concerning relationships and midwifery's move away from its concern with professional power hierarchies to a philosophy that prioritises woman centred care. However, woman centred care is not yet widely reflected in clinical practice and is therefore rhetoric. Byrom and Kay (2011) suggest that there are similarities between feminist theories and transformational leadership, particularly when it is employed to empower women. The development and use of the Multi-factoral Leadership Questionnaire (MLQ) by Bass and Alvolio (1994) demonstrated good evidence of the transformational leadership model's superiority through increased levels of job satisfaction, morale, motivation and performance (Bass, Alvolio & Goodheim, 1987, Bono & Judge, 2003).

Transformational leaders aim to influence their followers and bring about changes in their attitudes and behaviours towards the collective vision within the organisation. The expectation is that well-being, job satisfaction, increased effort and productivity are therefore raised (Alimo-Metcalfe & Alban-Metcalfe, 2005, Alimo-Metcalfe et al., 2007, Bass, 2008) which is important in professions, such as midwifery and nursing if they are to achieve better outcomes for their clients. Transformational leaders have vision, are inspirational, intellectually stimulating and/or individually considerate (Alvolio, Bass & Jung, 1999). They are charismatic, respect and empower staff to challenge the status quo and facilitate organisations to deal with change (Bass, 1985) which has become a feature of organisations in the 20th and 21st century. Tourish (2013, p. 27) however is critical of transformational leadership and of the power invested in this type of leader and suggests that we should take care against 'trusting too much in the judgement of others and not enough in our own'. He suggests that 'powerlessness corrodes our ability to take responsibility for our actions and manage our own destinies' (Tourish 2013, p. 27).

The US model of transformational leadership developed by Bass that relies on the influence of a charismatic, masculine, distant, powerful leader is not representative

of what front line staff, women or minority groups regard as effective leadership. Alimo-Metcalfe and Alban-Metcalfe's (2006) examined 'nearby' leadership using their transformational leadership questionnaire (Alimo-Metcalfe & Alban-Metcalfe, 2001). They asked an inclusive sample of (male and female individuals from different ethnic groups) managers at middle and top levels, from twelve health authorities and NHS trusts (n= 2013), and a similar number of local government organisations (n=1464), what distinguished the bosses they worked with, who had either outstanding, average or poor leadership skills. Very little difference between the NHS and local government organisations was found and a model of 'nearby' transformational leadership was developed that reflected 14 determinants of behaviour from the constructs that arose. The most important determinant was 'showing genuine concern for others' followed by networking and achieving, enabling others to lead themselves; being honest and consistent; being accessible; being decisive; focusing team effort; building a shared vision; inspiring others; encouraging change; supporting a developmental culture; resolving complex problems and facilitating change sensitively. The characteristics described appear to reflect leaders who successfully manage their hearts as well as their heads (Cottingham, 1994) and employ emotional intelligence (McQueen, 2004). Goleman (1995) suggests that emotionally intelligent individuals have the potential to inspire positive change through their interpersonal skills, ability to collaborate and to respond to their surroundings.

Alimo-Metcalfe and Alban-Metcalfe's (2001) model of transformational leadership differed from the US model in that their UK model recognises vulnerability in leaders who are open to ideas and advice. The US model was charismatic, visionary but somewhat heroic in nature and may not be appropriate for the softer caring skills required of leaders in the public sector. Alimo-Metcalfe's leadership model appears more appropriate in the health services where empathy and compassion are at the centre of care for clients. As Lewis (2000) suggests, being able to display appropriate

emotions demonstrates to his/her followers that a leader is able to respond to them appropriately. The attributes of caring, intuition and nurturing that appear to be feminist values and beliefs may balance the patriarchal values within the health services. Byrom et al. (2011) suggest that transformational leadership is an appeal for a responsive way of leading. It is important that models of leadership are relevant for the local area and inclusive of diverse views in individual organisations to ensure that the appropriate leaders are able to enhance engagement, morale and performance. Alimo-Metcalfe and Alban Metcalfe (2005, p.65) suggest this model of transformational leadership should be named the 'New, New Paradigm'.

Leadership in the National Health Service

The NHS organisational culture is perceived by many to be bureaucratic and hierarchical (Pollard, 2011, Warriner, 2009, Hurley & Linsley, 2007, Kirkham, 2007, RCM, 1998) and as such influences the values, beliefs and shared norms of those who practise within it (Sheridan, 2010). However, The King's Fund (2011) recently suggested that although the NHS is a £100 billion per year business, larger than British Petroleum and Shell, it only has 45,000 managers representing 3.6% of the workforce. It also suggested that historically leaders in most organisations have been identified as managers and held senior positions (The King's Fund, 2011) and much of the literature has focused in this area and espoused a heroic view of what leaders should be (Alimo-Metcalfe et al., 2007).

The perception of leaders as managers led to a growth in managerial concepts of leadership (Jasper, 2002). Management of the work force has been viewed as a well-oiled machine, hierarchical, with a senior management team that created instructions for others to follow (Morgan, 2006). Hierarchical respect and deference to authority, loyalty, following orders and life-long employment are also perceived to be characteristics of the culture of nursing and midwifery (Ford & Walsh, 1994, Warriner,

2009). Cook (2001a) suggests that nursing (and hence midwifery) has been dominated by transactional styles of leadership that reflect daily operations and goal setting and it is therefore unsurprising that a heroic style of leadership has developed.

The concept of leadership is central to the NHS modernisation strategy (Department of Health (DOH), 1997, DOH, 1999, DOH, 2004a, DOH, 2009a, DOH, 2010a, DOH, 2010b, Health and Social Care Act, 2012, Millward &g Bryan, 2005). The DOH (1999, 2000, and 2001) has developed several leadership initiatives in recent years, including the development of a Leadership Centre in April 2001, in response to the changes that continue to be made to services and culture (DOH, 1997, DOH, 1999, DOH, 2004a, 2004b, DOH, 2009a, DOH, 2010a, DOH, 2010b, Health and Social Care Act, 2012). The NHS Leadership Academy opened in April 2012 to develop future leaders and inspire current leaders to drive through improvements in patient care by providing programmes and support. A common set of NHS leadership qualities has been developed to set the standards for leadership excellence (DOH, 2002). The International Congress of Midwives (ICM) (2010), along with the Royal College of Midwives (RCM) (Johnson, 2012) also set up leadership programmes in response to the modernisation strategy. However, a lack of leadership in the NHS has been highlighted in reports, such as the Care Quality Commission (CQC, 2006), The King's Fund (2008) and Francis (2013). The reports associate a lack of leadership to poor care and an inability to change.

Millward and Bryan (2005, p. xx) suggests that 40 years of NHS management 'has not done much' to improve service delivery. However, the World Health Organisation (2008) suggested that consistent leadership is an important element to enhance the health of mothers and their children. The assumption is that leaders have vision, influence or power to see the vision through, facilitate the change process and solve organisational problems (Stanley, 2004, Ford, 2005). The *Strengthening Leadership in the Public Sector Report* (Performance and Innovation Unit, 2001), however, raised

concerns that the nature of leadership and the value of leadership development initiatives is not genuinely understood, which suggests that they may not be successful. The NHS Plan (DOH, 2000) stated that a 1940s NHS is operating in a twenty-first century world and needed to move from hierarchies with senior management teams that create instructions for others (Morgan, 1986), to a more flexible, adaptive and democratic system of collaborative individualism that supports having smaller systems, each with their own identity that also depend upon each other. Warriner (2009) suggests that currently the dominant leadership theories appear to be moving towards theories based upon relationships rather than hierarchical models. Leadership theories based upon relationships may be more able to support nurses' and therefore midwives' insights into clinical leadership.

Midwifery Leadership

The NMC Code (2015a, p.18) states that nurses, midwives and health visitors:

‘Provide leadership to make sure people’s wellbeing is protected and to improve their experiences of the healthcare system.’

(NMC 2015a, p. 18)

Traditionally, leadership positions in midwifery have tended to be associated with either management or more senior strategic roles within the service, such as heads of midwifery, matrons and consultant midwives, or within the RCM, the NMC and lead midwives for education (LME) within higher education institutions (HEIs) (Ralston, 2005). However, Curtis, Ball and Kirkham (2006a, p.140) found that a ‘them and us’ relationship amongst midwives located in practice and those in the managerial hierarchy that may have been related to the perceived distance between them. Alimo–Metcalf (2005) suggests that failures in leadership roles are often related to the isolation of those holding more senior management positions: visibility may enhance the effectiveness of leaders in clinical practice (Warwick, 2007). However, other leadership positions are held by midwifery team leaders, labour ward

coordinators and midwifery managers who support front line staff more directly (Byrom and Kay, 2011). Supervisors of Midwives, have until recently been supported in their leadership role within the NHS (DOH, 2008a, DOH, 2008b) and will continue to be founded in statute through the Midwives Rules and Standards (NMC 2012) until their imminent revocation by the Department of Health (2016a)². Other specialist roles have emerged around areas, such as safeguarding women and babies, substance misuse and risk management but appear to be associated with enhancing care for disadvantaged women rather than leadership roles.

The consultant midwife leadership role was introduced in an attempt to redress the balance of power between the obstetricians and midwives, remove the hierarchy and retain clinical expertise at the bedside (Sullivan, 2003, O' Loughlin, 2001). However, the creation of the position may have reinforced the hierarchy in the maternity services by adding another level. O'Loughlin (2001) suggests that the consultant midwife role may disempower other midwives by removing control over their work. The consultant midwife's lack of operational responsibility, and therefore power, may hamper her/his ability to change practice, and therefore requires that they practice alongside and are supported by their managerial colleagues. Not all NHS Trusts employ consultant midwives and therefore a lack of equity between hospital trusts exists.

The Failure of Midwifery Leadership

A lack of leadership in recent years has been recognised as contributing to the failure of maternity services to give good quality care to women (Kirkup, 2015, Centre for

² Supervision has been criticised for its reactive nature, support appeared to be needed by midwives (Stapleton and Kirkham 2000). A final report by Kirkup (2015) into failings in the maternity services at Morecambe Bay criticised supervisors of midwives and regulators for failing to protect the public through poor investigatory procedures and a lack of transparency and self-awareness. Investigations into Morecambe Bay maternity services led to the imminent removal from statute of the supervision of midwives and regulation of midwives resting solely with the NMC (Parliamentary and Health Service Ombudsman 2013).

Maternal and Child Enquiries (CMACE), 2011, DOH, 2009b, CQC, 2008, The King's Fund, 2008, CQC, 2006, Health Care Commission (HCC), 2006, HCC, 2004), which Johnson (2012) suggests may have hindered the development of midwifery as a profession. Lavender and Chapple (2004) found that the midwives in their study suggested that a lack of leadership led to practice being based on the preferences of the consultant obstetrician. The midwives wanted midwifery leaders that were strong, supportive, who valued their input and who were able to facilitate normal care in the hospital environment that was dominated by the medical model of care (Lavender & Chapple, 2004), which suggests that facilitating midwifery care in hospital may be difficult. However, Lavender and Chapple's (2004) findings suggest that leadership and other qualitative aspects of the organisation, such as support and feeling valued may have a greater impact on the outcome of care for mothers than we suppose. The development of effective midwifery leadership may therefore be required to raise the midwife's profile and facilitate practice.

The suggestion that leadership has ethical foundations, such as the requirement to be honest, accountable, trustworthy and empower others (Pashley, 1998) was not upheld by the investigation into maternity services in Morecambe Bay that uncovered a lack of midwifery, medical and managerial leadership, associated dishonesty and a dysfunctional culture (Kirkup, 2015). Dysfunctional relationships between the midwives and obstetricians and tensions relating to their polarised discourses led midwives to avoid involving the obstetrician in women's care in a bid to normalise it. However, the Kirkup (2015) report found a lack of insight by the midwives into when women's care deviated from normal and required obstetric assistance that left the women and babies in their care vulnerable. Johnson (2012) cites one of reasons for a lack of leadership in midwifery may be related to a lack of awareness amongst midwives with regard to their leadership role and professional responsibility. If Johnson (2012) is correct, however, it suggests that midwives may be in breach of

their professional body requirements that confer their status as the lead professional for low-risk women (NMC 2012).

Although, I suggest that midwifery leadership has been lacking, Coggins (2005, p.196) highlights several challenges in the maternity services that require 'strong' leadership, such as increasing litigation, change, an ageing workforce, a recruitment and retention crisis. Dunkley-Bent (2015) highlights the competition for resources in an NHS with finite resources as another difficulty. Dunkley-Bent (2015) also suggests there may be difficulties enhancing midwifery leadership due to a male dominated NHS. The link forged between leadership and management may also have stifled midwifery leadership (Coggins, 2005). In the past midwifery leadership was related to management positions (and may still be currently), however, may create dilemmas for the leader/manager through the tension between facilitating change and the management of resources. I would suggest that as midwifery is one of the smallest professions in the NHS it is often underrepresented in higher education institutions and amongst health professions, and a lack of midwives at a strategic level within trusts and universities may disadvantage them. Midwifery leadership may be important if midwives wish to retain their autonomy, develop strategic thinking, contribute to innovation in practice (Pashley, 1998) and facilitate safe and effective care for women.

Midwifery Culture

In the United Kingdom nearly all midwives practice in a variety of settings within the NHS. Over the past century the hospitalisation of birth, under the auspices of safety, that continues to be challenged and was unsubstantiated at the time (Tew, 1990), has resulted in increasing medicalization and affected the midwife's position in terms of the authority of her/his knowledge in practice. However, Oakley (1993) suggests that medical authority has arisen through claims that midwifery knowledge is

unscientific rather than determining the benefits of their own practices. Mander and Murphy Lawless (2013) also suggest that the safety of hospital birth has been challenged over the last twenty five years by authors, such as Tew (1990) and the Birthplace in England Collaborative Group (2011). Despite the challenges made against hospital birth for low-risk women midwives, on the whole, continue to facilitate low-risk birth within hospitals. The hospital environment has created tensions for midwives. A disjuncture exists between the midwifery profession's espoused values and the reality of practice that Deery, Hughes and Kirkham (2010, p. 50) termed 'professional dissonance' and difficulties for midwives related to their ability to practice 'normal' midwifery, or to be the type of midwives they want to be (Donnison, 1988, Hunt & Symonds, 1995, Sandall, 1995, Mackin and Sinclair, 1998, Kirkham, 1999, Begley, 2002, Stapleton, Kirkham, Thomas & Curtis, 2002, Hollins Martin & Bull, 2008, Hughes, Deery & Lovatt, 2002, Hyde & Roche-Reid, 2004, Hunter, 2004, Lankshear, Ettore & Mason, 2005, Kirkham, 2007, Russell, 2007, Matthews & Scott, 2008, Keating & Fleming, 2009, Sheridan, 2010, Pollard, 2011, Freemantle, 2013, Mander & Murphy Lawless, 2013, Bedwell, McGowan & Lavender, 2015).

Midwives as an Oppressed Group

The difference in power between UK midwives and obstetricians appears to be responsible, to some extent, for the domination of midwifery practice. Kirkham's study of the culture of midwifery in England, in 1999 suggested that midwives lacked rights as women, such as empowerment and having a voice, which they were required to offer to their clients. Kirkham (1999), Stapleton, Kirkham & Thomas (2002), Matthews and Scott (2008), Pollard (2011) and Bedwell et al. (2015) found midwives were unsupportive of one another and midwives who were supportive role models were pressured to toe the line: guilt and self-blame were commonplace, as was a sense of fatalism with regard to their inability to affect change and lack of a voice. Midwives continue to be an oppressed group.

Hollins, Martin and Bull (2006) found that midwives were obedient to authority through a lack of power and autonomy, or to avoid retribution and for fear of litigation. However, Jowitt (2008, p 5) suggests that midwives are 'bystanders' who look on and do nothing whilst women are mistreated and that being part of a large group, in a large organisation, midwives appear to lose their individuality and autonomy. It is easier to 'keep their heads down' and comply with the group if midwives are to feel safe. Duff (2005, p.185) described 'tall poppy syndrome' to suggest midwifery leadership is 'risky', in that those tall poppies who raise their heads above the proverbial parapet, often get their heads chopped off. It is therefore sometimes better to comply as it may be 'exhausting' to do otherwise'. As a consequence of by-standing behaviour, however, midwives become disempowered by the system and each other (Jowitt 2008). Foucault (1982) suggests that people often perceive that they are disempowered and that empowerment is something that they receive from those in power, as opposed to empowerment being within their own reach, should they wish to take it. It may be that midwives will have to stop by-standing and demonstrate courage if they are to practice midwifery within the NHS.

The pressure for midwives to conform to the obstetric model has led to midwives demonstrating resistance through 'doing good by stealth' (Kirkham, 1999, p.734, Begley, 2002, Stapleton, Kirk, Thomas & Curtis, 2002, Pollard, 2005). In a bid to practise midwifery and normalise care for women, midwives use subversive means, such as keeping doctors away from women, staying in the woman's room and underestimating progress in labour to facilitate women extra time in which to achieve a normal birth (Hunt & Symonds, 1995, Russell, 2007, Kirkham, 1999). The obstetrician's power may have led some midwives to use covert resistance or reject the value in their own traditions by identifying with medical practices that ensure some status. Freire (1993) suggests that the process of internalising the values of the more powerful group, the more the original features of the oppressed group are valued

negatively. Midwifery knowledge may therefore become subjugated, as was apparent in Shallow's (2001) study that examined the experience of midwives who were integrated into teams. The midwives' own knowledge was undermined by more authoritative medical knowledge and they found themselves forced to adapt to different practices.

Pollard, Ross and Means (2005) posit that the history of the medical dominance of nursing and midwifery may be the reason these professions focus on their relationship with doctors over others when considering inter-professional working. However, Mackin and Sinclair (1998), Kirkham (1999), Lavender and Chapple (2004) and Hunter (2005) submit midwives participate in their own oppression and maintain the status quo. They found that midwives policed practice, as well as using bullying behaviour or what Leap (1997, p.689) and Curtis, Ball and Kirkham (2006b, p.218) described as 'horizontal violence' against those who did not conform to the dominant medical discourse (Mackin and Sinclair, 1998, Kirkham, 1999, Lavender and Chapple, 2004 and Hunter, 2005). Freire (1993) suggests:

'During the initial stage of the struggle, the oppressed, instead of striving for liberation, tend themselves to become oppressors or 'sub-oppressors'. The very structure of their thought has been conditioned by the contradictions of the concrete, essential situation by which they were shaped.'

(Freire, 1993, p.27)

Although Freire (1993) suggests the oppressed are aware of their position in the hierarchy, they do not strive to be free of the oppressor but to assimilate the oppressor's behaviour in an attempt to retain some status. Should these findings apply to midwives in the labour ward environment it may be difficult to envisage how midwifery clinical leadership on labour ward is enacted and whether they are able to employ a midwifery philosophy of care, normalise care, facilitate change and enhance the experience of the women they care for.

Ideological Tensions and Power

‘The definition of normal and abnormal birth, is, of course, crucial to the distinction between skilled and semi-skilled work. It marks the boundary upon which the whole professional hierarchy of skill is legitimised.’

(Hunt & Symonds, 2005, p.141)

One of the reasons that midwives perceive they are unable to practise as they want is related to the tension between the obstetric ideology³ of care that runs counter to that of midwifery: that birth is risky and in need of surveillance and management, as opposed to pregnancy and childbearing being usually normal physiological processes. Hunter (2004) found that this tension between the two ideologies was a source of emotion work for midwives and the tension has also been found to lead to low morale and midwives leaving the profession (Ball, Curtis and Kirkham, 2003).

Taylor (1999) and Hunt and Symonds (1995) suggest that a hierarchy of power exists in maternity services with the obstetricians at the top, the midwives in the middle and women at the bottom. Midwifery appears to have been ‘impeded’ by the ‘colonisation’ of labour and birth by the technocratic model of obstetrics and the ‘quest’ of ‘modernity’ to control nature (Hyde & Roche, 2004, p. 2614). Hunt and Symonds (1995) and Kirkham (1999) suggest that medicine has defined midwifery through its sphere of practice and the ‘normal only in retrospect’ medical view has been associated with minimising risk in the professional and popular imagination and has become the authoritative approach over the last century (Downe, 2002). As I alluded to earlier in this chapter, the medicalization of birth appears to have happened, even though the majority of women experiences normal pregnancies and birth (National Childbirth Trust (NCT), 2009), the drivers of maternity care continue to espouse the normalisation of care and the development of midwife led care, that to some extent

³ I refer to ideology or philosophy as interchangeable concepts throughout the thesis to refer to the beliefs and values that underpin practice that may be, and are different for particular clinicians.

has been reflected in the opening of birth centres in some hospital trusts (DOH, 1993, DOH, 2004c, DOH, 2007, DOH, 2016b).

Downe and Finlayson (2011) suggest that those in power dictate the social norms, and as historically the majority of obstetricians have been male, the norms for maternity care are therefore masculine and biomedical. Hunt and Symonds (1995, p. 35) suggest midwifery, that is a predominantly female profession, appears to have been culturally prevented from 'the exercising of authority which restricts its influence in the masculinised, public world of health service management'. Hunt and Symonds (1995, p.33) also argue that whilst midwives may hold power and authority within the confines of their daily practice, being able to exercise power and authority 'outside this sphere is problematic'. Whilst I suggest power and authority are combined they may be perceived as separate concepts: power may be merely coercive, such as physical or emotional threat, whilst authority may be viewed as a legitimated form of power.

Kirkham (1999) suggests that the professionalization of midwifery moved a midwife's loyalty from the woman to the profession and therefore distanced from its beliefs and values. Professionalism is related to the raised status of an occupational group that enjoys the control of its work (Freidson, 2004). However, Freidson (2004) also suggests for an occupation to become a profession it must undertake specialised work that is not available to those outside it. Ironically, midwifery, in its pursuit of professional status may have carved out its place as a semi-profession, allied, although, inferior to medicine.

Downe and Finlay (2011) suggest that the medicalization of childbirth has been accepted by both midwifery academics and leaders internationally to the extent that it has become the term that represents current maternity care. With such an emphasis on medicine and pathology there may be little wonder doctors are the

controlling force in care provision (Begley, 2002). Gould (2000) suggests professions that dominate services decide where resources are allocated and this is why there are increasing numbers of consultants on labour wards, but funding the one to one care of women has not been forthcoming. She also suggests that rather than 'being with women', midwives are 'being with others', such as the obstetrician or the organisation (Gould, 2000, p.481) and that dependency may facilitate the dominant group to confer their values and beliefs on those who are compliant. Powerful midwifery leaders may therefore be required if change is to be made.

Labour ward

Of all the areas within maternity services, the labour ward is where midwives and obstetricians (and other members of the multidisciplinary team, such as anaesthetists and paediatricians) have most contact. This close relationship and the context within which midwives work appears to have impacted upon their practice. Hunt and Symonds's (1995, p.139) ethnographic study of labour ward likened the organisation of hospital birth to that of a:

'Masculinised, industrial, factory production process due to the shift system, line management structure, an emphasis on production targets, strategies for getting through work and the pursuit to regularise an unpredictable work pattern'.

(Hunt & Symonds 1995, p.139)

Bedwell et al. (2015) suggest that midwives who practise in hospital often do so in a hierarchical culture within an organisational, technocratic model of care, 'clear the board mentality'⁴ (Hunter, 2005, p. 257). Labour ward has been associated with a 'culture of 'busyness' (Sheridan, 2010, p. 83).

'To those working on labour ward, life is all consuming. There is little time or energy left to step back and consider the complexity of events and

⁴ Most labour wards have white boards where information is written with regard to the women who were present on the ward. A clear board represented work had been completed.

interactions. There is even less time to consider what it all means and why midwives do some of the things they do.'

(Hunt & Symonds, 1995, p. 39)

Regardless of whether midwives are busy or not, care is being driven by organisational demands and doing is valued over being (Sandall, 1995, Hunt and Symonds, 1995, Hunter, 2004, Walsh, 2006). Kirkham (2007, p. 1) suggests that care is given by midwives in short bursts to an 'endless number of women they will never see again' and that does not enhance job satisfaction nor lead to effective care giving. Woman centred care may be perceived to be more time consuming, as it supports investment in women's psychological and emotional well-being alongside her physical needs: its practice and multidisciplinary communication may therefore be limited by a heavy workload (Porter, Crozier, Sinclair, Kernohan, 2007, Berridge, Mackintosh & Freeth, 2010). Sheridan (2010) suggests that care on labour ward is task oriented and tension exists between the completion of tasks and providing effective care. The midwives in Sheridan's (2010) study used routine to gain control, however, the routines were driven by organisational demands and were fixed and inflexible. This type of control may also detract from a woman centred approach to care. Sheridan (2010) also found an ongoing acceptance of midwifery authority but this espoused culture was not practised. Schein (1992) suggests a culture's beliefs and expectations represent its true essence and are demonstrated by the way people behave rather than by the statements they make. If a midwifery culture is not seen in practice it may be viewed as merely rhetoric.

Labour wards and the midwives who practice within them appear to have some authority within the maternity unit (Russell, 2007, Russell, Walsh, Scott & McIntosh, 2014): their presence may be tangible in other areas. The power conferred upon some labour ward midwives suggests power or influence may be vicariously attributed to them through an association with the obstetrician. Midwifery practice on the labour ward has also been associated with an acquiescence to the dominant

medical discourse and ways of working (Bedwell et al., 2015, Russell et al., 2014, Hastie & Fahy, 2011, Sheridan, 2010, Keating & Fleming, 2009, Russell, 2007 Lankshear et al., 2005, Walton, Yiannousiz & Gatsby, 2005, Hunter, 2004, Hunt & Symonds, 1995) that may inhibit change or the ability to facilitate midwifery practice.

Hastie and Fahy (2011) find that negative interactions between midwives and obstetricians involved power struggles that were associated with adverse outcomes, and also safety concerns (Berridge et al., 2010). Walsh (2011) suggests that midwives may struggle to reconcile their beliefs about birth in this type of setting and these struggles may impact on midwives' psychological health (Mackin & Sinclair, 1998). However, Russell et al. (2014) and Lankshear et al. (2005) also found that the midwifery leaders on labour ward, although sometimes overruled by the obstetricians, were influential in changing behaviour and facilitated change or reinforced medicalised clinical practice. Bedwell et al. (2015) suggest that the shift leader on labour ward may impact on the confidence of midwives. Midwifery leadership on the labour ward may therefore represent an opportunity for midwives to facilitate change and facilitate practice in line with their midwifery discourse.

Literature Review

Despite leadership being perceived as important within the NHS, a literature review with regard to midwifery leadership (see Appendix 2 for searches, retrieval and appraisal methods) retrieved a dearth of primary empirical studies. Three studies were identified relating to midwifery leadership, Byrom and Downe (2008), Kay (2010) and Divall (2015) (see Appendix 3). I acknowledge, however, that although Divall's (2015) study relates to midwifery leadership it also refers to clinical leadership and could have been discussed in the following chapter. However, I perceived the midwives in the study to have some distance from practice as they held mostly managerial leadership positions, as midwifery matrons. The most appropriate place

to discuss Divall's (2015) findings appeared to be alongside the midwifery leadership literature.

Byrom and Downe (2008) explored what a group of midwives, from a range of midwifery areas considered to be a 'good' leader using a phenomenological approach. Kay (2010) and Divall (2015) examined the transition to a leadership position of two different groups of midwives. Kay's (2010) critical ethnography explored the experience of community team leaders of leading teams and Divall (2015) employed narrative identity theory to examine midwifery leaders/managers' narratives of identity. None of the studies was concerned with midwifery leadership on the labour ward. All three studies were conducted in England, employed a qualitative methodology, purposive sampling (although some randomisation was employed by Byrom and Downe (2008) to achieve a sample of midwives with a variety of experience (n = 10). Byrom and Downe's (2008) study was the only one that included midwives practising on labour ward, although it is not clear how many and whether the findings were representative of their views. Whilst the use of small samples in qualitative research is acknowledged as appropriate it is acknowledged that wider inference may not be possible, although this depends upon whether the findings hold any reality beyond the context within which they were found (Ritchie and Lewis 2003).

The aim of Byrom and Downe's (2008) interview survey of midwives of different grades or pay bandings was to gain insight into what characteristics midwives felt that 'good' leaders and 'good' midwives possessed, rather than to answer specific questions. The study was similar to appreciative inquiry as the authors sought to examine positive rather than negative aspects of leadership and practice. Whilst concentrating on positive aspects of leadership and midwifery it may have focused the findings in this respect, however, negative practices were also uncovered. The views of more experienced midwives were represented more than the less

experienced which may have influenced the findings. Kay (2010) used a critical ethnographic approach to examine community midwifery team leaders' experience of leading other midwives in their teams. She interviewed five community midwifery team leaders, examined documentation and conducted participant observation of the activities of two of the four midwifery teams that provided an antenatal, postnatal and homebirth service and therefore only offers the views of community midwives and may not represent the views of the midwifery leaders practising in a hospital environment. Divall (2015) also explored the narratives of midwifery clinical leaders. However, the nine midwifery leaders in Divall's study held more senior leadership positions in the NHS hierarchy than those in Kay's (2010) study, making comparison difficult. A range of views of midwives from all the pay bandings were therefore represented in the literature, although not all the leadership positions that I suggested earlier in the chapter were, such as supervisors of midwives, labour ward coordinators, consultant midwives or heads of midwifery.

Clinical Credibility and Identity

Byrom and Downe (2008) and Divall's (2015) findings suggest that the clinical credibility of midwifery leaders was valued. Divall (2015) finds that midwifery leaders who were employed in strategic⁵ roles, such as matrons, heads of midwifery and midwifery lecturers perceived their clinical credibility, as midwives, to be important (Divall 2015). However, being removed from clinical practice rendered, visibility and clinical credibility to be a challenge. The midwifery leaders demonstrated a strong affiliation to their group when they stated 'I am still a midwife' (Divall, 2015, p.1064) and sought to maintain their clinical credibility in ways other than giving direct care, such as managing women's complaints and supporting midwives through their roles as supervisors of midwives.

⁵ I suggest 'strategic' to refer to those midwifery leaders who are removed from the clinical area and are responsible for more strategic work, rather than the day to day running of the clinical areas.

Divall (2015, p.1065) describes a tension in the leaders' identity as 'individuation', as they sought distinction as midwifery leaders but also similarity to their professional group as midwives. Individuation was first described by Brewer (1991) and proposed by Divall (2015, p. 1065) to be 'part of the compromise involved in dealing with tensions between individuals' need for uniqueness and distinction, and the need for validation and similarity to others'. The dualistic nature of midwifery leadership was perceived for the midwifery leader to be 'between a rock and a hard place' (Divall 2015 p.1063) and suggests that tension exist.

Byrom and Downe (2008) found that the ability to act knowledgeably and competently and generate feelings of safety (which suggests the clinical environment may be fearful), was seen as a basic requirement for both clinical midwives and leaders. Clinical credibility appeared to be an important aspect in the acceptance of midwifery leaders by their peers (Divall, 2015). Being credible at a strategic level was what distinguished the leader from the clinician in Byrom and Downe's (2008) study. However, Divall (2015) found that the midwives in strategic leadership positions were perceived negatively as managers. Divall (2015) suggests that for strategic midwifery leaders to counter the negative perception of themselves requires support from their professional group and a clinical component being part of their work. Lavender and Chapple's (2004) findings also suggest that the midwife manager was seen as someone who must command clinical respect and have status. Possessing a degree of authority or power and visibility in practice may therefore be necessary if strategic midwifery leaders are to be successful, however, this may be difficult to achieve.

Although the community midwifery team leaders in Kay's (2010) study appeared to have a good understanding of what it meant to be a good leader, such as being dynamic and being a good listener, they did not emphasise clinical competence. This appears interesting as it is anticipated that community team leaders engage in clinical practice. However, they may not give direct care in close proximity to other midwives

and therefore do not have opportunities to demonstrate clinical expertise. The community midwifery team leaders appeared to be unclear of their identity: their strategic responsibility and what marked out the team leader from the manager i.e. where their position as team leader ended and their line manager's position began, which may affect their credibility as a team leader. Both Kay (2010) and Divall (2015) suggest that support for the midwives' leadership positions, from the organisation and their peers may facilitate clear and positive leadership identities.

The midwives suggested that being a community team leader involved being a change agent (Kay, 2010). The midwives in some of the units in Lavender and Chapple's study (2004), however, suggested that their manager devolved responsibility to the obstetricians and this created a barrier to change in terms of promoting normality. However, practising in the community and out with the hospital environment may have freed the midwifery leaders in Kay's (2010) study from the pressure to conform. The community team leaders felt they were not adequately prepared for leadership and although they appeared to enjoy the job, felt that they were overwhelmed by their workload and did not transmit a positive view of team leadership. The lack of a positive perception of team leadership may deter more junior midwives from taking up the role in the future (Kay, 2010). Lavender and Chapple's (2004) study also recognised the leadership training and continuing professional development programmes were required for leaders and commented on the lack of role models in the clinical areas. Handy (1993) suggests that leadership skills are learned by working with positive role models and therefore the lack of this may impact on future midwifery leadership.

Emotional Intelligence

Possessing status and clinically credibility alone, however, may not be seen as a guarantee of being a good leader. The midwives in Byrom and Downe's study (2008) suggested interpersonal skills and the appropriate use of positional power was also

required. Whilst Byrom and Downe's (2008) study focused upon 'good' midwifery leadership, negative aspects of midwifery leadership were also highlighted, such as the link between a leader's misuse of power and their loss of touch with the ethos of midwifery care. Most of the midwives suggested an empathetic approach was required and valued approachability, warmth, caring, friendliness, respect, gentleness, humility, support, empowering and adaptability in the leader's personality which suggests a degree of emotional intelligence. Goleman (1995) suggests emotional intelligence is a kind of social intelligence that enables a person to examine his/her own emotions and those of others and to use this to facilitate acting and thinking. The impact of being empowered by effective role models who use particular approaches of care to empower women may be described as a 'virtuous circle' (Evans and Wolfe, 2005): in that it sustained trust and belief in the midwife which subsequently empowered her/him to trust and believe in the women she cared for. Byrom and Kay (2011) suggest that if midwifery leaders can empower women they have the potential to empower their followers.

Midwifery Leaders: 'Hard' or 'Soft'?

Whilst the midwives suggested 'good' leaders were those who possessed emotional intelligence and who were able to empower and support others, it was also anticipated that they have some professional distance as leaders (Byrom & Downe, 2008). Possessing both 'soft' and 'hard' characteristics ('soft' may refer to the emotional, caring aspects of the position and 'hard' to the definitive decision-making responsibility and control) appeared necessary prerequisites for midwifery leaders and reflects the duality and tensions for the midwifery leaders in Divall's (2015) study, of being both different to other midwives, because of their position, and yet the same due to their allegiance with the midwifery profession as midwives. However, the midwives in Byrom and Downe's (2008) study were reticent with regard to associating caring with leadership as they perceived the two as not totally compatible. The

historic association of leadership with masculine characteristics and heroism may have coloured their perceptions, however, a mix of both characteristics appeared to be a requisite of midwifery leaders and resonates with the ethos of the midwifery discourse that prioritises relationships and caring.

Summary

Leadership appears to be an important concept. The importance attached to the notion of leadership may be seen in the plethora of literature on the subject, the perception that leaders are vital for organisational success and its perceived ability to facilitate change. However, some authors suggest that leadership is a myth that supports the maintenance of hierarchies. Power is associated with the notion of leadership as it is conceived as a relationship of influence over followers or subordinates. However, followers may be important as they contribute a significant proportion of the success of organisations. Leadership that does not recognise the importance of followers may lead to the dependency and deskilling of others. Theories of leadership have developed over the last sixty years from espousing leaders as heroic and masculine, to post heroic, transformational models that are more inclusive and engender caring and empathy that appear more suited to the practice in the public sectors, such as nursing and midwifery. Management and leadership have been closely aligned in the past, although currently management is associated negatively with bureaucracy and a transactional style, as opposed to leadership, being more positive and transformational. It has been suggested however, managerial qualities are required of leaders in a hierarchical and bureaucratic NHS. Leadership appears difficult to define and may differ depending on the context in which it is located. An understanding of leadership may therefore require an understanding of local meaning.

The bureaucracy in the NHS may have been responsible for the spread of managerial concepts of leadership and appears to have led to a culture that comprises a deference to authority by nurses and midwives. The hospital labour ward environment has been described as a culture of 'busyness' and is one in which midwives are in close contact with the obstetrician. This combination has led to a masculinised, industrial factory processing of birth that is task oriented, incapable of providing woman centred care and devalues midwifery practice. Midwifery culture does not appear to be evident and therefore espoused midwifery values may be perceived as rhetoric. Most midwives practise within the NHS as a result of the medicalization of childbirth on the premise that hospital birth is safer, a premise that is currently being successfully challenged. The polarisation of the medical and midwifery discourses and the dominance of midwifery by obstetrics is causing midwives professional dissonance, inhibiting midwifery practice and subjugating midwifery knowledge. Midwives appear to be an oppressed group and as such adopting the oppressors' behaviour, practising midwifery covertly, policing practice, becoming bystanders and maintaining the status quo in an attempt to regain status and position. Midwifery leaders may require courage to lift their heads above the parapet to prevent by-standing if midwifery is to be represented in clinical practice. Should the midwifery leaders on labour ward demonstrate oppressed behaviour it is difficult to see how they are able to give safe midwifery care. However, midwifery leaders on labour ward have been associated with influencing behaviour and developing confidence they may therefore represent an opportunity to facilitate change and develop midwifery practice.

There is a dearth of primary empirical research with regard to midwifery leadership and none related to leadership within the labour ward. The literature available suggests that clinical credibility is an important aspect of midwifery leadership, although for some strategic midwifery leadership positions it may be difficult to attain.

Midwives appear to want strong leaders who facilitate safety and security which suggests that practice is fearful. A degree of power and status is implicated for midwifery leaders to be successful and a balance between possessing emotional intelligence and maintaining professional distance suggests some dualisms and tensions are inherent in the leadership position. Enhanced leadership development may be required to provide effective role models to facilitate the future development of midwifery leaders. Midwifery has been associated with poor leadership that may impact upon the development of midwifery as a profession. However, the challenges for midwifery, such as increasing litigation, change and the competition for resources require strong midwifery leadership if the challenges are to be addressed.

There is currently no UK research that addresses midwifery leadership on the labour ward. However, a concept that appears to represent midwifery leaders on the labour ward, who are at the front line of midwifery services delivering care is that of clinical leadership. Clinical leadership will be the focus of the following chapter.

CHAPTER THREE: CLINICAL LEADERSHIP

Clinical leaders in nursing or midwifery are:

‘Nurses [or midwives] directly involved in providing clinical care who continuously improve care and influence others.’

(Cook, 2001a, p.33)

Introduction

The perceived importance of leadership as a concept was discussed in chapter two (p.25). This chapter will critically discuss a review of the existing literature with regard to clinical leadership in midwifery and nursing to locate the research within it. A summary of the methods employed to retrieve and critically appraise the literature can be found in Appendix 2. In addition to the research on clinical leadership, opinion and policy documents are used throughout the chapter to provide depth and critical analysis. Whilst systematic searches were undertaken to retrieve relevant literature a narrative account of the literature retrieved will follow and will highlight any methodological considerations. The background to the current rise in the interest of clinical leadership and how it is defined will be discussed to synthesise the existing evidence and identify research gaps.

The Rise of Clinical Leadership: ‘No More Heroes’

The Department of Health (DOH, 1997, 2000, 2008a), The Prime Minister’s Commission on the Future of Nursing and Midwifery in England (2010), The King’s Fund (2011, 2012, 2013, 2014 a, 2014b, 2015), NHS England (2014), Naylor, Dorrell, Everington, Lewis, Morgan, Serrant and Stanton (2015) have all proposed placing a new emphasis on facilitating NHS staff to lead and manage the organisations in which they work. These documents make the case for staff who are based in practice to influence and participate in strategic planning, lead services and develop policy. Emphasis is placed on the importance of self-aware leaders, who enhance the quality of front-line care, become patient centred, reduce the cost of clinical practice, give

direction and purpose, and inspire their teams. The King's Fund (2011, p. ix) suggests the move is leadership 'from the board to the ward' to challenge poor practice. It recommends that the old model of heroic leadership by individuals should become one that integrates models of shared, collaborative leadership that focus on followership as well as leadership.

The emergence of clinical leadership in the NHS may have benefits for the improvement of direct care and as Goodwin (2000) and Hurley and Linsley (2007) suggest, supplementing clinical work with valued leadership creates a clinical leader, rather than a clinician with management training. Nurses and midwives deliver eighty percent of care, therefore the advent of clinical leadership and that front-line staff should play a critical role in implementing the new NHS is not surprising (Jasper, 2002). Lord Laming (2003, p. 6) suggests that clinicians must 'lead from the front' if services are to change. Naylor, Dorrell, Everington, Lewis, Morgan, Serrant and Stanton (2015) also suggest that in a chaotic healthcare environment front-line leaders are required as they may understand the complexities of such an environment more than an executive leader who is removed from clinical practice. Cook (2001b) suggests that healthcare is leaving behind an industrial age of process oriented, functional work and is moving towards whole system thinking and purposeful work. Leadership is moving from transactional through to transformational, connective to ultimately become 'renaissance' (Cook, 2001b, p.39). Cook (2001b) suggests that renaissance leadership is the ultimate goal where empowering relationships occur between clients and the nurse or midwife. However, due to the realities of present day organisational life, where hierarchies and bureaucracy prevail, heroic leadership behaviours continue to exist and therefore post heroic discourses of leadership appear to be ideology rather than reality (Martin & Learmonth, 2010).

Clinical leadership appears to be antithetical to the general management of the 1980s which employed market practices and 'marginalised clinicians as hired artisans' (Warwick, 2011, p.308). It has been suggested by Warwick (2011) that market practices failed in NHS England as it is not a business and clients with their complex health problems are not commodities. However, she also suggests that what may be required is a 'faculty of management of health services where management dependent on equal partnership of clinical and non-clinical professionals and where appropriate training is trialled and promoted' (Warwick, 2011, p.309). Ham (2003) also suggests that both clinical and managerial leadership may be warranted to facilitate change in the health services.

Alarm and Crisis in the NHS

The existence of a negative culture at Mid Staffordshire NHS Trust and a widespread lack of effective leadership that resulted in unsafe and poor care was reported by Francis in 2013. A subsequent survey with regard to culture and leadership also found that a discrepancy exists between NHS staff and their leaders' views about their working environment and culture that suggests leaders are out of touch with staff on the front line of care (The King's Fund, 2014b). Patient-centred leadership that values and supports staff, facilitates team working and collaboration, and creates leaders who place their clients at the centre of their care appears to be all the more urgent to become a reality (The King's Fund, 2013).

There appears to be a discourse of crisis in the NHS. Naylor et al. (2015) suggest that amongst the reasons for the crisis is a blame culture, increased surveillance through audit and clinical guidelines, political exposure that renders clinicians vulnerable to criticism on a strategic level and a lack of support that fosters a reluctance of staff to move into leadership positions. The view is that only some 'major shift in the way we work [in the NHS] can save us' (Checkland, 2014, p.255). Barker

(2001, p.478) states that the 'alarm' regarding a lack of leadership is a sign of 'increasing social despair and learned helplessness'. Gemmill and Oakley also suggest that:

'When pain is coupled with an inordinate, widespread and pervasive sense of helplessness, social myths about the need for great leaders and magical leadership emerge from the primarily unconscious collective feeling that it would take a miracle or messiah to alleviate or ameliorate this painful form of existence.'

(Gemmill & Oakley, 1992, p.273)

Checkland (2014, p.254) concurs with Gemmill and Oakley and states that 'magical' powers have been attributed to clinical leadership, and it has emerged due to the failure of management and is part of the wider discourse of crisis in the NHS. She also suggests that there may be practical difficulties in distributing leadership to clinicians as it is not clear who the followers necessary for leadership will be and whether clinical leaders will move between leader and follower positions (Checkland, 2014). Storey and Holti (2013, p.128) suggest that perceiving clinical leadership as a 'cure all' for the NHS 'underestimates the challenge for clinical leaders'. However, perceiving leaders to be saviours in times of crisis may foster dependency. Samuels (2001) suggests that our emotional investment in strong successful leaders may have affected our capacity to recognise that they arise from a sense of unhappiness. However, Edmonstone (2009a) suggests that such comments may reflect the viewpoint and potential anxieties of senior managers and doctors who may be threatened by clinical leadership as it may impact negatively on their dominant position, rather than emphasising effective clinical leadership facilitating health care in practice.

Front line leadership: the ‘disconnected hierarchy’

‘Improvement of the performance of health care depends first and foremost on making a difference to the experience of patients and service users, which, in turn, hinges on changing the day-to-day decisions of doctors, nurses and other staff.’

(Ham, 2003, p.1978)

Clinicians on the front line of care may be strategically placed to deliver what Ham (2003) suggests above. Malby (1998) suggests clinical leadership has arisen from a need to highlight the leadership potential within nurses or midwives who practice clinically. She also suggests that it is an attempt to differentiate between positional leadership and personal leadership and to demonstrate that hierarchy is not the only source of power (Malby 1998). Charisma, competency and expertise are also sources of power that nurses and midwives may employ (Jarman, 2007). Edmonstone (2009a, p.293) also suggests that a ‘disconnected hierarchy’ exists in health care, and is a key feature of professional organisations. In hierarchies power is invested in those at the top and whilst Edmonstone (2009a) recognises the existence of this type of hierarchy in the NHS to a certain extent he describes health care staff in Marxist terms as the ‘operating core’ and the ‘means of production’ to illustrate where their power lies (Edmonstone, 2009a, p.294). In a disconnected hierarchy the professionals at the bottom of the hierarchy delivering clinical care have greater influence and discretionary control over the day-to-day decisions that are made with regard to that care. Greater influence may occur despite the policy and guidelines that are in place to guide a clinician’s care giving. Decision making in practice is not straight forward and indicates developing clinical expertise that takes into account multiple factors, such as what expertise may be necessary, the conditions in the clinical environment and the individual client. The influence that managers or politicians have may therefore be more limited than in other organisations. It would seem appropriate therefore that the means of facilitating

change from the bottom up is feasible and that clinical leadership may be a mechanism to enable this change.

As providers of front-line care midwives and nurses appear to be in a position to offer clinical leadership that is necessary to provide optimum care to clients (Casey, McNamara, Fealy & Geraghty, 2011) and is where their power lies (Davidson, Elliott & Daly, 2006). However, as I have already suggested in chapter two (p.45), midwifery power has historically been constrained due to the dominance of a medical discourse, knowledge and their position in the professional hierarchy, where doctors are positioned at the top and other healthcare professionals below (Wilcocks, 2012, Currie & Lockett, 2011, Kirkham, 1999). Clark (2008) suggests that nurses may not perceive themselves as leaders as they associate leadership with authority. Although clinical leaders or bed-side leaders can make significant differences to care and the lives of the people they engage with (Stanley & Sherratt, 2010), they often have low status and have been generally unrecognised and undervalued (Stanley, 2008). If a rigid, authoritarian, professional hierarchy continues in the NHS, midwives may be unable to assert their identity and clinical leadership may become 'rhetoric, rather than practice' (McKeown, 2015, p.316). A collaborative, empowering and supportive culture may be necessary to support the kind of clinical leadership that is envisioned (Millward & Bryan, 2005, Murphy, Quillan & Carolan, 2009).

Defining Clinical Leadership

I opened this chapter with Cook's (2001a) definition of clinical leadership and suggested in chapter one (p.21) that my own definition of a clinical leader in midwifery is 'a clinically credible midwife who has up-to-date knowledge, is able to guide and empower other midwives to positively influence appropriate midwifery care and who advocates for women'. However, defining the concept of clinical leadership, as with leadership, is particularly difficult as different ideas of the meaning of the term exist.

Stanley (2008) argues that the distinctive nature of clinical leadership has continued to be unrecognised and unappreciated because of the difficulty in producing a standard definition. However, this may also be due to clinical leadership being a relatively recent term (Stanley & Sherratt, 2010). Clinical leadership is a term that is used in addition to or alongside the term nursing management or nursing leadership (Lett, 2002). Edmonstone (2009a, p.291) perceives clinical leadership to be 'leadership by clinicians of clinicians' and Millward and Bryan (2005 p. xv) suggest it is about 'facilitating evidence based practice to improve patient outcomes through local care'. Bed-side (Lett, 2002, Honour, 2013), front-line (The Prime Minister's Commission on the Future of Nursing and Midwifery in England, 2010), distributed/democratic (Gronn, 2008, Bolden, 2011), collaborative (Coombs, 2014), and patient-centred and practice in relation to clients' or women's concerns and wishes (The King's Fund, 2013) are all terms that are used interchangeably with clinical leadership and cause confusion. Although the definitions of clinical leadership appear similar, the continued lack of a standard definition and title may impact upon its practice and development.

Clinical Leadership in Midwifery and Nursing

Midwifery Clinical Leadership: is required

A dearth of empirical literature exists with regard to clinical leadership in midwifery. No studies were uncovered that related to clinical leadership on the labour ward. One study relating to clinical leadership in midwifery by Divall (2015) was retrieved. However, as stated in chapter two, I chose to discuss this alongside the midwifery leadership literature to facilitate its discussion (see p.47-52). Although clinical leadership was not the focus of Marshall, Spiby, and McCormick's (2014) and Spiby, Green, Richardson-Foster, and Hucknall's (2013) studies, their findings suggest it was implicated in the facilitation of change. Spiby et al. (2013) aimed to identify the

triggers for changes to early labour services and how they were monitored in NHS Trusts in England. A postal questionnaire survey (with a response rate 89% that suggests most of those surveyed were represented within their findings) and semi-structured telephone interviews with a purposive sample of heads of midwifery or a designated senior midwife (n=17). The clinical leaders at the front line of care were found to be key to the success of early labour services as they were able to persuade other staff of the requirement for change. Marshall et al's. (2014) study supports the findings of Spiby et al. (2013). Marshall et al. (2014) evaluated the Focus on Normal Birth Programme that was implemented in the maternity units of twenty NHS Trusts in England as a strategy to reduce the number of potentially unnecessary caesarean sections. The rate of caesarean section in the UK and around the world is higher than the World Health Organisation suggests it should be and although it influences morbidity positively it may also do so negatively. The evaluation comprised a web-based survey of healthcare professionals (n = 54, 67.5%) and service users (n = 11, 55%). Sixteen semi-structured interviews with a range of health professionals and two service users (n = 18) from six of the twenty trusts were also undertaken. The findings suggest that the engagement and enthusiasm of the labour ward lead midwives and clinical leaders in other professional groups were significant motivators of the initiative. The Trusts who achieved the lowest caesarean section rates were those Trusts who had more of these types of leaders involved in the programme. It appears that clinical leaders in midwifery are able to effectively develop services through inspiring others to follow their lead and are therefore required.

Clinical Leadership in Nursing

As only one empirical study was found with regard to clinical leadership in midwifery the nursing literature was examined to discover what was already known that may be relevant. Mander (2004, p.132) suggests that 'some may rightly question the relevance of nursing literature [to midwifery] on the grounds that nurses and midwives are fundamentally different groups'. I acknowledge the differences, however, a common nursing background continues to apply to some older midwives, and nurses may be the health care profession most closely aligned to midwifery to make comparisons. Twenty-seven empirical studies are included in the review (see Appendix 4). Whilst most of the studies relate to nursing a small number of the participants in the senior and specialist positions were midwives and therefore a limited account of midwifery views is present. The research was conducted in England, Ireland, America, Canada, Australia and New Zealand using purposive samples to locate the clinicians to be studied. However, all have similar health care systems and practices and are therefore comparable. The nursing literature relating to clinical leadership considered several areas that are represented in Table 1.

Whilst the development of clinical leadership within the literature appears to be important to the future of clinical leadership it is not within the remit of this thesis and therefore will not be explored (for further insight into clinical leadership development see: Ennis, Happell & Reid-Searle, 2015a, Phillips & Byrne, 2013, Swanwick & McKimm, 2012, Casey, McNamara, Fealy & Geraghty, 2011, Pepin, Dubois, Girard, Tardif & Ha, 2011 and Cunningham & Kitson, 2000).

Table 1: Clinical Leadership Literature in Nursing

Topic	Author(s)
Advanced practice and clinical leadership: the advanced practitioner, clinical nurse / midwife specialist practice nurse and nurse practitioner.	Bousefield (1997), Cook (2001b), Donnelly (2005), Carryer, Gardner, Dunn, Gardner (2007) Burns (2009a, 2009b, 2009c), Carney (2009), Mayo, Agocs-Scott, Khagani, Meckes, Moti, Redeemer, Voorhees, Gravell and Cuenca (2010), Roberts, Floyd & Thompson (2011), Matthew-Maich, Ploeg, Jack & Dobbins (2012), Elliott, Higgins, Begley, Lalor, Sheerin, Coyne & Murphy (2012), Wickham (2013)
The team leader	Martin & Waring (2012)
Nurses in senior positions: the matron, ward sister/charge nurse and consultant nurse	Christian & Norman (1998), Connelly, Yoder, Miner-Williams (2003), Royal College of Nursing (RCN) (2004), Redwood, Lloyd, Carr, Hancock, McSherry, Campbell & Graham (2006), Gould (2008), Manley, Webster, Hale, Hayes & Minardi (2008), RCN (2009), Mitchell, Butler-Williams, Easton, Ingledew, Parkin, Wade & Warner (2010), Franks & Howarth (2012).
Nurses' perceptions of clinical leadership characteristics	Stanley (2006), McNamara, Fealy, Casey, Geraghty, Johnson, Haligan, Treacy & Butler (2011), Stanley (2014), Ennis, Happell & Reid-Searl (2013), Mannix, Wilkes & Daly (2015)
Implementing clinical leadership	Storey & Holti (2013)

Nurses as Clinical Leaders

I suggested in chapter two, that historically, in nursing and midwifery the common belief is that the leader of a ward or a service is the most senior nurse, nurse manager or ward sister/charge nurse. Clinical leadership is also ascribed to senior positions (Stanley, 2006), such as consultant nurses, matrons and advanced practitioners. The lack of a career pathway for clinical nurses and midwives who wished to remain in clinical practice, as well as a drive to improve the quality of care and reduce financial pressures, led to the development of senior positions associated with clinical leadership. The posts created in the UK and abroad were the modern matron, consultant nurse/midwife, advanced practitioner/specialist nurse and clinical nurse/midwifery specialist (DOH, 1999a, 2000, 2003, Donnelly, 2005, Carryer, et al., 2007, DOH, 2008b, Mayo, et al., 2010, Roberts, et al., 2011, Matthew-Maich et al.

2012). The introduction of these positions has emphasised the importance of clinical leadership. It would appear logical therefore that these clinical leadership positions in nursing are the subject of most research studies.

There appears, however, to be a lack of empirical research with regard to those clinical leaders who hold less senior clinical leadership positions. The clinicians at the front line of care that policy suggests are to be the future clinical leaders are therefore not well represented. The study by Martin and Waring (2012) is the only empirical research retrieved to do so. They examined the team leader/ theatre coordinator who practice on the 'coal face', at the 'constrained' centre of practice (Martin & Waring, 2012, p.359) that suggests being in the middle of the hierarchy restricted the team leader/ theatre coordinator's power. The findings of Stanley in 2006 and 2014 also suggest that clinical leadership is not only tied to a hierarchical position but also to other characteristics associated with the leader, such as their values. Whilst the response rates from the surveys undertaken by Stanley (2006, 2014) were low (22.6% and 41.6% respectively), the similarity between the findings of the two studies that were conducted in different countries and with different health professionals enhances their credibility. Storey and Holti (2013) also found that clinical leadership exists at many levels within the NHS and that it should not be underestimated. If future clinical leadership is envisaged to be distributed amongst those clinicians practising at the front line of practice more research may be required to explore it in these areas.

Power, Authority and Legitimacy

One of the characteristics that has been associated with clinical leadership, as I suggested earlier, is seniority of position and therefore a degree of status within the UK NHS hierarchy. Whilst the hierarchical position of the clinical leaders in Christian and Norman's (1998) study, appeared to be important within the interdisciplinary team, position alone did not always assure their authority (power to influence others)

in practice. The advanced practitioners (Bousefield, 1997, Cook, 2001a, Donnelly, 2005, Burns, 2009a, Carney, 2009, RCN, 2009, Elliott et al., 2012.), team leaders (Martin & Waring, 2012) and some of the nurses in more senior clinical leadership positions (Christian & Norman, 1998, RCN, 2004, Redwood, et al., 2006, Franks & Howarth, 2012) lacked power, were largely unsupported, isolated and not recognised by others. There appeared to be several factors associated with the ability of clinical leaders to access power.

A professional hierarchy that reflected the primacy of the medical model appeared to impact upon those nurses in clinical leadership positions. The dominance of medicine as a profession and the perceived supremacy of medical knowledge appeared to be a barrier to health professional collaboration (Storey & Holti, 2013). Whilst legitimacy is afforded to medicine through the general acceptance of its power and superior status, its legitimacy, in the sense that it is 'right' and therefore an appropriate approach to health care may be contested. However, medical superiority influenced negative attitudes to the clinical nurse specialist, as others were suspicious of the clinical nurse specialist's remit (Bousefield, 1997), practice nurses relied on 'being allowed to' practise as clinical leaders by the general practitioners who often employed them (Burns, 2009b, p.521); it hindered the ability of the theatre coordinators who are situated close to the bottom of the professional hierarchy to influence quality care (Martin & Waring, 2012) and led to the gatekeeping of leadership development opportunities and access to meetings (McNamara, et al. 2011). However, Martin and Waring (2012) found that where perceived differences in power between professionals were aligned, the theatre coordinators were able to impact upon decision making and care giving. Followership and influence may therefore be more about a clinical leader's ability to practice freely in the context of their environment rather than being due to the formal position held.

In the absence of power other mechanisms were employed to impact decision-making. The practice nurses in Burns' (2009a) and clinical nurse specialists in Carney's (2009) study used peer support as a means of solidarity to enhance their influence. In response to medical opposition, bureaucratic authority in the form of national directives, guidelines and protocols were used to support and facilitate the theatre coordinators and practice nurses' ability to contribute to decision-making (Burns, 2009c, Martin & Waring, 2012). National guidelines and policies hold bureaucratic power as there is an expectation that they are to be followed by all as a means of enhancing safety and effective care. Clinical expertise was also perceived to be important in determining the authority of the clinical leader as it was respected. Carryer et al. (2007, p.1822) suggest professional expertise or 'efficacy' implies a 'level of practice that is supported by significant autonomy and accountability'. Although it appears that the clinical leaders in some instances were able to compensate for a lack of power, Martin and Waring (2012) suggest that clinical leadership is required to be one part of a wider strategy that appreciates the impact that the acquiescence or opposition of key stakeholders may have on prospective clinical leaders.

Authority appeared to be associated with the accountability for the management of resources. The support from their peers with administrative responsibilities facilitated the clinical leadership of the practice nurses in Bousefield's (1997) study to develop practice. In contrast, the clinical leaders in nursing development units, without management responsibility possessed little authority to influence change (Christian & Norman, 1998). Whilst most of the studies suggest that one of the central characteristics of clinical leadership is to develop practice (Christian & Norman, 1998, Cook, 2001b, Redwood et al., 2006, Manley, et al., 2008, McNamara et al., 2011, Elliott et al., 2012, Matthew-Maich et al., 2012, Wickham, 2013) the power associated with some of the clinical leaders in the literature suggests that this may be restricted.

Nurses (and other health professionals) in subordinate positions, without recourse to management support or responsibility may be inhibited by formal hierarchies and find practising clinical leadership difficult. The alignment of hierarchies and a degree of, or shared managerial responsibility may be required if clinical leaders in nursing (and midwifery) are to practice successfully.

Whilst consultant nurses appear to be associated with definitive competencies, such as leadership, education, research and clinical expertise that facilitated their ability to function (Mitchell et al., 2010), others were less well defined. Bousefield (1997), Connelly et al. (2003), RCN (2004), Gould (2008), Burns (2009a), Roberts et al. (2011) and Elliott et al. (2012) suggest that the clinical leadership positions that have arisen lack clarity and are practised in a variety of ways. The demands of clinical leadership positions that were not clearly defined meant that unrealistic goals were set and high workloads, 'burn-out', a lack of time to lead and maintain their clinical skills were some of the experiences of the clinical nurse specialists (Bousefield, 1997, Carryer et al., 2009, Elliott et al., 2012), practice nurses (Burns, 2009a), consultant nurses (Roberts et al., 2011, Franks & Howarth, 2012) and Matrons, (RCN, 2004, Gould, 2008).

A lack of understanding with regard to clinical leadership may have contributed to its influence being reduced and to an increased resistance from other professionals. Some nurses did not perceive themselves to be clinical leaders (Stanley, 2006, Carryer et al., 2007, Burns, 2009a, Carney, 2009, Martin & Waring, 2012), although the nurses in Stanley's (2006) study were recognised by their peers as such. Interestingly most of the theatre coordinators in Martin and Waring's (2012, p.366) study preferred the title of 'sister' or 'staff', as 'leader' lacked kudos and was threatening to all in a context where professional designations were the norm. Organisational norms appear difficult to change. A lack of preparation for nurses becoming clinical leaders is also evident (Cook, 2001b, Connelly et al., 2003,

Donnelly, 2005, RCN, 2009, Carney, 2009, Roberts et al., 2007, Franks & Howarth, 2012, Martin & Waring, 2012). Experiential learning appeared to be valued and therefore most clinical leadership skills were developed through practice (Martin & Waring, 2012), rather than education which may in itself lead to a diversity of clinical leader practice. A lack of development for clinical leaders may result in fewer skills and an inability to facilitate change. The failure of front-line nurses (or midwives) to recognise their clinical leadership potential may both inhibit its development and prevent their recognition as such. Clinical leadership in nursing appears to be tenuous as it is poorly identified and prepared for, and its remit unclear. Franks and Howarth (2012) suggest that clinical leadership in nursing may therefore be perceived as unnecessary and easily removed.

Clinical Expertise, Advanced Practice and Identity

Clinical expertise appears to be an essential characteristic of clinical leadership. Harper (1995, p.81) suggests that a clinical leader 'possesses clinical expertise in a speciality practice and uses interpersonal skills to enable other health care providers to deliver quality care'. Clinical leaders are 'expert nurses who lead followers to better health care' (Lett, 2002, p.20) or who undertake 'activities supporting the development of practice in the [health] service' (Elliott et al., 2012, p.1039). The specific reference to 'clinical activity' sets the clinical leader apart from the 'generic nurse leader, who is defined as 'a nurse that creates new ways of working' and nurse manager which refers to 'implementing new ways' (Cook, 2001a, p.39). Most of the studies in the review suggests that clinical expertise is the most important characteristic of the clinical leader (Christian & Norman, 1998, Cook, 2001a, Connelly et al., 2003, Donnelly, 2005, Stanley, 2006, Redwood et al., 2006, Burns, 2009a, Carryer et al., 2007, Manley et al., 2008, Gould, 2008, Mayo et al., 2010, Mitchell et al., 2010, McNamara et al., 2011, Martin & Waring, 2012, Matthew-Maich et al., 2012, Elliott et al., 2012, Wickham, 2013). 'Being there' (Burns, 2009a, p.467) and being

available for advice and support on the front line was perceived to be a characteristic associated with clinical leadership and with safety (Connelly et al., 2003, Donnelly, 2005, Carryer et al., 2007, Gould, 2008, McNamara et al., 2011, Martin & Waring, 2012, Wickham, 2013). Clinical leaders appeared to be judged with regard to the proximity to the people for whom they care.

McNamara et al. (2011), however, suggest that those in formal management positions may not be best placed to be clinical leaders, due to their distance from practice. Whilst I suggested earlier that the clinical leadership nursing posts were developed to keep senior nurses close to practice, Franks and Howarth (2012) suggest that in reality this has not occurred. The literature suggests that those clinical leaders, such as matrons, ward sisters and consultant nurses who are, to varying extents removed from direct care giving on a day to day basis, encounter difficulties securing time to practice clinically (Bousefield, 1997, RCN, 2004, Gould, 2008, Burns, 2009a, Carryer et al., 2007, Roberts et al., 2011, Elliott et al., 2012, Franks & Howarth, 2012). However, Mitchell et al. (2010) suggest that the consultant nurse may be different to other advanced practitioners, clinical nurse specialists, matrons and ward sisters. Whilst the consultant nurses appeared to share some of the difficulties related to a lack of authority and heavy workloads, they had strategic, rather than front line responsibility. Although they possess extensive experience in their fields, such as public health nursing or the protection of adults or children, they use 'higher order skills' to develop vision, strategic plans and to communicate these across boundaries (Mitchell et al., 2010 p.481). The consultant nurse or perhaps the consultant midwife may therefore not be representative of front line clinical leaders. It may be that those clinical leaders practising closer to the front line who are lower in the hierarchy have a more local impact and that those higher have a strategic impact for which different skills are required.

Clinical leadership in nursing appears to be associated with advanced clinical expertise and knowledge: an extension to their scope of practice (Donnelly, 2005, Carryer et al., 2007, NMC, 2012). However, Carryer et al. (2007) suggest that the extension of nursing practice refers to its increasing proximity to medicine. They suggest that the 'knowledge continuum is hierarchical with medical ability as the pinnacle of achievement that is secured at the expense of nursing ability' (Carryer et al., 2007, p.824). The extension of the midwife's practice in the past has also followed the same continuum. Labour ward practices, such as perineal suturing, facilitating instrumental birth, undertaking the first examination of the newborn baby have all historically been medical practices that are now performed by midwives. Franks and Howarth (2012, p.853) suggest that nurses in advanced posts may be described as 'second class doctors'. It may be difficult to demonstrate a unique professional identity if practice functions are interdisciplinary.

McNamara et al. (2011) suggest that professional recognition and an ability to affect changes to care rely on being able to clearly express the profession's contribution. Donnelly's (2005) examination of the advanced practitioner in Canada recognises that an added medical function was a feature of their practice. However, the advanced practitioners suggested that they balanced care with cure and therefore perceived themselves to be a bridge between medicine and nursing. The advanced practitioners' perception appeared to be an attempt to render medicine holistic, preserve their identity as nurses through being mindful of their values and thereby allaying any worries that nursing practice is missing through the adoption of a medical task.

Martin and Waring (2012) highlight that encouraging the theatre coordinators to demonstrate clinical leadership was an attempt to reassert professional values in the face of increasing managerialism in clinical work, although Martin and Learmonth (2012) suggest that it may have been a ploy to modify the identity of professionals in

a bid to facilitate an acceptance of managerialism in their practice. Professional leadership that employs leadership activities that align with national and international developments in a profession outside of the health service may have the potential to instil the values of the profession into clinical care and clarify its contribution. Carryer (2002) also suggests that it is not the actions but the professional philosophy that defines the nature of the profession. Stanley (2006 and 2014) found that the clinical leaders in his studies were identified by the relationship between their values and clinical practice. The practice nurses in Burns' (2009a, p.467) study also referred to being able to 'practice what they preach was a feature of clinical leadership'. Stanley (2008) subsequently developed a Congruent Leadership Theory that appeared best suited to understand clinical leadership in nursing as it defines leadership in terms of a match between the activities, actions and deeds of the leader and the leaders' values and beliefs (Stanley, 2008). Stanley and Sherratt (2010) defined a clinical leader as:

'A clinical expert in their field and who because they are approachable and open, effective communicators, visible in practice, positive clinical role models, empowered decision makers, clinically competent and clinically knowledgeable, and *significantly, displaying their values and beliefs through their actions*, are most likely to be seen as clinical leaders.'

(Stanley and Sherratt, 2010, p.117)

Congruent leadership may therefore be a means of preserving professional identity. McNamara et al's. (2011) national study to examine Irish nurses' views of clinical leadership suggests that one of the four components of the clinical leader position, that underpins all others, is to represent the nursing contribution to care. The incorporation of values into the day to day practice of nurses may be a means of representing this input. However, as I suggested of midwives in chapter two (p.42), a lack of power may encourage nurses (and midwives) to assume the professional discourse of others as a means of securing representation in a multidisciplinary context. Elliott et al. (2011), suggest that the clinical leadership of the advanced

practitioners was inward looking and institutional as it focused on the priorities of the organisation within which they practised rather than their profession.

The work of the clinical leader in nursing was also described as 'coordination' (Christian & Norman, 1998, Elliott et al., 2011, McNamara et al., 2011, Roberts et al., 2011, Martin & Waring, 2012). The coordination of work was related to administration rather than leading: a means of getting the work done and was the responsibility of nurses on the whole to facilitate the smooth running of the practice environment due to its busyness and being short staffed. McNamara et al. (2011, p. 23) describe coordination as 'compensatory action' as it results in the nursing clinical leaders filling gaps to provide a seamless service. Redwood et al. (2007) and McNamara et al. (2011) suggest that practising in this compensatory manner blurs the boundaries between nursing and medical practices and the impact of nursing on care becomes invisible during the process (McNamara et al., 2011). Whilst Storey and Holti (2013) suggest that health professionals practise in silos which hinder multi-professional working, boundaries may be important (although may need to be permeable to facilitate collaboration with others). Boundaries facilitate nurses to 'define and set the parameters of their own professional practice and to articulate their distinctive contributions to effective healthcare' (McNamara et al., 2011, p.26). A strong professional discourse and an ability to 'beat our drum' (Redwood et al., 2007, p.37) may be required if nursing and midwifery are to be valued and to prevent the erosion of professional identity and status.

'Effective Goodness': Clinical Leader Characteristics

Characteristics equated with or are desired of clinical leadership within the literature, were being approachable (Burns, 2009a), having effective communicate skills (Christian & Norman, 1998, Connelly et al., 2013, Ennis et al., 2013, Wickham, 2013), being motivational (Carney, 2009, Martin & Waring, 2012, Matthew-Maich, 2012, Ennis et al., 2013), teaching others (RCN, 2009, Roberts et al., 2011, Elliott et al.,

2012, Wickham, 2012, Connelly et al., 2013, Ennis et al., 2013), being supportive (Cook, 2001a, Burns, 2009a, RCN, 2009, Roberts et al., 2011, Ennis et al., 2013, Wickham, 2013), fair (Connelly et al., 2003), being honest and possessing integrity (Ennis et al., 2013), caring, being respectful towards others and demonstrating professional values (Christian & Norman, 1998, Cook, 2001a, Connelly et al., 2003, Stanley, 2006, Redwood et al., 2006, Ennis et al., 2013, Stanley, 2014, Mannix et al., 2015). These relational skills appear to be requisite for clinical leaders to nurture and protect their followers and are associated with emotional intelligence. Goleman (2013) suggests emotional intelligence is the ability of individuals to identify their own emotions and those of others, to comprehend diverse feelings and describe them appropriately, and to employ emotional information to influence their actions and thinking. Emotional intelligence may assist in the creation of a good practice environment that helps followers to focus on the priorities associated with giving care (Cook & Leathard, 2004).

Mannix et al. (2015) examined what nurses perceived to be 'aesthetic', less tangible leadership qualities in clinical leaders qualities, such as sensory and emotional awareness. Some of the aesthetic dimensions they valued were sensitivity, communication, support and approachability. The clinical situation shaped which aesthetic was used. Sensitivity to clients was demonstrated during care-giving, being welcoming and making others feel comfortable was attributed to the setting and during individual encounters, and within the team, support, empathy, listening and calm approaches were identified as aesthetic. Ennis et al. (2015b) also found, being calm and confident in times of crisis were features of effective clinical leadership. Mannix et al. (2015, p.2655) suggest these aesthetic qualities represented 'effective goodness' as the embodiment of the aesthetic qualities in the clinical leader that created a positive and calm influence when situations became difficult. The development of aesthetic and transformational qualities in clinical leaders may

facilitate nursing and midwifery practice in environments, such as labour wards where a heavy workload, high risk and emergency care is usual.

One of the characteristics the nurses perceived to be least associated with clinical leadership was risk-taking. I suggested in chapter two (p.30) that being risk averse may be associated with cultures where blame and control is prominent and may inhibit learning and innovation. Mannix et al. (2015) suggest that this may have been a gendered response as most of the respondents were female and as such may prefer not to take risks, although they acknowledged little evidence is available to support this in health care. The transformational and aesthetic characteristics associated with clinical leadership in nursing appear to be soft skills. However, some nurses (Burns, 2009a, p.467) suggest that clinical leaders were required to be 'professional yet human': their position required recognition and distance but simultaneous humility and approachability. The characteristics required may differ depending on the health profession and the context of the practice environment.

I suggested in chapter two (p.32) that transformational leadership qualities appear to align well with the values espoused in midwifery and may be a means of representing the profession clearly. However, whilst transformational leadership is concerned with possessing the preceding qualities it is also associated with the transformation of followers to pursue a joint vision (Alimo-Metcalfe & Alban-Metcalfe, 2006). The consultant nurses in Mitchell et al's. (2010) study who practised at a strategic level were closely associated with having a vision for the service. Although Cook (2001a) did not find clinical leaders to be visionary he suggests that creativity in the clinical leader facilitated the generation of new ways of working. However, one of the significant findings of Stanley's (2006, 2014) research was that vision was not what identified the clinical leaders at the front line of care. The clinical leaders may have possessed a vision, however, it was not what motivated other nurses to follow them. Stanley's findings led him to question whether transformational leadership could be

equated with clinical leadership and whether a congruent theory of leadership is more appropriate for the caring professions.

Summary

The rise of front line clinical leadership appears to be driven by the government and the current discourse of crisis and helplessness in the NHS. Clinical leadership is perceived as a mechanism to improve the quality of care, provide patient centred services and reduce costs. However, clinical leadership, similar to leadership, is difficult to define. The newness of the term and a lack of recognition may lead to clinical leadership being under-valued and developed. Front-line leaders who practise in a disconnected hierarchy may be best placed to enact this type of leadership and directly impact care. However, there is some concern that excessive dependence is invested in clinical leaders and that the challenges they face is underestimated. A culture of collaboration may be required to facilitate their success.

A review of the literature retrieved a dearth of empirical studies with regard to clinical leadership in midwifery, although it appears to be required to facilitate changes in practice. No studies involving clinical leadership and the labour ward were found. Most of the nursing literature relating to clinical leadership is attributed to advancing nursing practice and the associated nursing positions, such as the advanced practitioner, clinical nurse specialist/clinical midwife specialist and nurse practitioner; more senior nursing positions, such as the ward sister/charge nurse, matron and consultant nurse. Whilst some of these positions involve clinical practice, the lack of a clear definition and heavy workload rendered their ability to impact clinical care directly difficult. One study examined the theatre coordinator, a position related to front line leadership that the drivers of care currently espouse and therefore a gap in the literature exists

Whilst the positions above designated nurses as clinical leaders, position alone did not appear sufficient to facilitate their ability to develop practice. However, the development of practice is one of the expectations of clinical leadership. Many were unsupported, lacked recognition in a medically-dominated professional hierarchy. The lack of a clear definition of some positions also led to unrealistic expectations, a varied approach to implementation and a lack of recognition. The nursing clinical leaders relied on the support of others for their authority or used mechanisms to facilitate their involvement in decision making. A lack of administrative responsibility restricted the clinical leaders to affect change and therefore an association with a degree of managerial responsibility was aligned with success. Clinical leadership may need to be clearly defined as a component part of a broader strategy that recognises the impact of the potential barriers to clinical leadership if it is to be successful.

Advancing practice and clinical expertise is correlated with an extension of the nurses' scope of practice through the addition of medical tasks. The knowledge continuum is therefore hierarchical as it is aligned to the accrual of medical skills. Extended practice and the coordination of care appears to render nursing identity and its contribution to care invisible. Professional leadership, professional boundaries and congruent leadership theory and a strong professional discourse (and an acknowledgement of the nurse's clinical leadership potential) that places values at the centre of care may ensure that the contribution of nurses and midwives is not lost.

The characteristics subscribed to clinical leaders in nursing were related to those of transformational leadership. Whilst some nursing clinical leaders were associated with possession a vision, they were mostly those nurses in senior strategic positions. Those clinical nurse leaders practising closer to their clients were designated as such because of their values rather than their vision. Congruent leadership may therefore

better represent those front line clinical leaders in nursing and midwifery rather than transformational leadership.

This research aims to explore clinical leadership on the labour ward. The objectives are:

- To critically explore clinical leadership on the labour ward in relation to power and professional discourses.
- To critically examine the characteristics attributed to clinical leadership.
- To critically explore the characteristics attributed to those clinicians identified as effective clinical leaders on the labour ward.
- To critically examine the experience of being a clinical leader on the labour ward

The following chapter will set out the methods employed to meet the aims and objectives of the research.

CHAPTER FOUR: METHODOLOGY AND METHODS

Introduction

This chapter will explore the use of a critical ethnographic methodology to meet the aim and objectives of the study. The ethical considerations within the study will be considered throughout the chapter. Reflexivity, the preparations made to enter the field and the methods used to collect and analyse the data will be discussed.

Ethnography

Harper (2011, p.1) suggests that choosing a research methodology is a 'pragmatic undertaking': the methodology ought to reflect the research questions, although other factors are considered, such as the researchers' epistemological and ontological stance. A qualitative approach was taken based on the ontological premise that social interactions and their meanings are constantly occurring and that individuals actively construct their social world that is perpetually changing (Ormston, Spencer, Barnard & Snape, 2014, Letherby, Scott & Williams, 2013, Bryman, 2016). This is antithetical to the positivist view that suggests social phenomena are external facts beyond personal reach or influence. Qualitative approaches are valuable as they permit the exploration of the diversity in cultural and personal beliefs, values, ideals and experience (Luborsky & Rubinstein, 1995). Ethnography as a methodology was chosen in the belief that social reality has meaning for people and human action is meaningful. Ethnography may enable access to the common sense thinking of the midwives on the labour ward and to interpret their actions and social world from their point of view.

Ethnography is concerned with the study of culture (Hammersley & Atkinson, 2010) and is the 'totality of all learned social behaviour of a given group' (Thomas, 2003, p.12). It is characterised by an eclectic use of methods, such as observation, interviewing and reviewing documents that facilitates the development of insight into

interactions and acts beyond which may be understood from the use of verbal data alone (McNaughton, Nicholls, Mills & Kotecha, 2014). Hunt and Symonds (1995) employed an ethnographic approach to study labour ward midwives and recognise the work of a midwife on a hospital labour ward was complex. They suggest that ethnography offered a broad approach to see what happened and to ask what the actions meant. A phenomenological design is concerned with similar participant experiences, rather than shared culture (Creswell, 2013) and the study of every day social interaction. It therefore seems less relevant for this study.

Hammersley and Atkinson (2010) suggest that in the past ethnography was employed to provide a descriptive account of a community or culture. However, ethnography does not currently have a standard, well defined meaning. Hammersley and Atkinson (2010) suggest that the change may be due to the association of ethnography with various methodological approaches and theoretical ideas. From a sociological perspective simple causal relationships cannot explain the social world. Human behaviour is premised upon social or cultural meanings, such as a peoples' intentions, motives and what they believe and value (Letherby, 2003).

Leadership is derived from social interaction processes (Northouse, 2016, Bass & Alvolio, 1994) through which, one individual influences others toward the achievement of group or organisational goals. Employing an ethnographic approach therefore appeared appropriate to understand the culture of leadership on the labour ward where social interaction and influence appear to be central to care giving and team function. The match between a clinician's values and actions has also been identified as being key to the identification of clinical leaders in practice (Stanley, 2006). Blumer (1962 cited by Bryman, 2016, p.14) suggests that interaction takes place in a way that the individual is continually interpreting the symbolic meaning of his/her environment that includes the action of others and subsequently acts on this meaning. Hammersley and Atkinson (2010) suggest that to understand behaviour an

approach that gives access to the meanings that guide the behaviour may be most appropriate.

Critical Ethnography

Thomas (1993) suggests that 'critical' ethnography emerges when those members from a culture of ethnography become reflexive and not only ask what things are but what they could be. It is conventional ethnography with a political purpose that requires that common sense assumptions are questioned. Research approaches that are 'critical' are not the same as descriptive or interpretive approaches as simply stating the cultural context may not have been sufficient for the understanding of clinical leadership on the labour ward. However, Hammersley and Atkinson (2010) suggest there is currently some similarity between critical and descriptive approaches within ethnography, such as the importance of seeing experiences through the eyes of the research participant.

A critical ethnographic approach was chosen as it can emphasise relationships that involve inequalities and power but also involves helping those without power to acquire it (Thomas, 1993). As discussed in chapter two (p.40) midwives practising on the labour ward have been identified as an oppressed group by Kirkham in 1999, by virtue of their domination by an obstetric philosophy of care over a midwifery philosophy. This may be compounded by their predominantly female gender (Letherby, 2003). The obstetricians appear to hold symbolic power, in that preferred meanings have been appropriated and alternatives suppressed. Repression is a condition in which thought and actions are constrained in ways that prevent the recognition of alternative possibilities (Thomas, 1993, pg. 4). Carsprecken (1996) suggests that if we are aware of the potential dominance of one ideology over another, critical ethnography may be the most appropriate methodology to use to understand the culture. I understand ideology to be a term that may be used

interchangeably with discourse, to represent the philosophy that underpins care giving i.e. in midwifery that birth is a normal physiological event. I recognise that employing a feminist lens that recognises the various oppressive circumstances women experience as problematic and is geared to achieving social justice for them (Creswell 2013) may have been applied to this study. However, employing a critical ethnography appeared to be more suitable for both acknowledging any oppression and at the same time examining clinical leadership as a cultural phenomenon.

Critical ethnographers attempt to identify the process by which cultural repression occurs then reflect on the possible sources and suggest ways of resisting it (Thomas, 1993). Carsprecken (1996) suggests that the essential features of critical research methodology are epistemological. At the heart of a critical epistemology is the belief that unequal power distorts truth claims e.g. consent can be coerced or beliefs silenced by the authority of a more powerful belief of power, and works towards emancipatory change with the research participants. I concur with Weber (1997), Foucault (1980) and Bourdieu (1989) who believe that in most social action power plays a role and that without exception every kind of social action is influenced by domination of one kind or another.

Critical epistemology is based on an assumption that society is not equally structured. Grbich (2009) contends that society is controlled by hegemonic practices that develop and uphold a particular world view and that the researcher should be actively involved in the critical analysis of the world view. To this end this study also employed the feminist principles of enabling others to find their voices (giving voice), addressing inequality, challenging traditional power relationships with a commitment to bring about change (Letherby, 2003). For critical thinkers, Thomas (2003, p.34) suggests that the ontological assumption is that there is something underneath the surface world of accepted appearances that can reveal the oppressive side of social life. Critical realists believe that we may only understand the social world if we recognise

the structures that make things happen and that create discourses and that these structures are not clearly observable in a particular pattern of events (Bryman, 2016).

A common criticism of critically oriented research that suggests social constraints exist and that research should be emancipatory and directed at the overcoming of constraints, is that it starts from a value-laden position (Madison, 2012). However, all research designs require certain assumptions with regard to social reality and human experience. The process of choosing a subject to research in itself is not a value free activity: it may make basic claims about the fundamental features of a person's view point. The adoption of a grounded theory methodology that suggests the researcher begins with no pre-existing theory or experience appears to be at odds with a critical perspective, although I recognise that grounded theory findings may reveal inequality or power differences.

Whilst I am aware that there have been suggestions that midwives are oppressed it does not mean that I presumed the midwives in the research would be. However, this was explored as part of the research process. Willis (2007) also suggests that critical theory research focuses on negative aspects rather than the positive work done from a critical perspective and rarely brings about change. However, whilst the study aimed to be critical there was also a focus on the positive attributes of clinical midwifery leadership and how this knowledge may lead to change. A tension existed during all aspects of the study as I was aware of the responsibility I owed to the participants and my profession as a whole to adopt a balanced and considerate approach and at the same time, to ensure an honest and critical appraisal of the data. Acknowledging this tension and being aware of it may demonstrate the authenticity of research (Guba & Lincoln, 1994) in the knowledge that I represent the participants of the research fairly.

Research for Change

Employing a critical ethnography appears to imply a more active role with the participants for the researcher. Hammersley and Atkinson (2010) suggest that to be of value critical ethnographic research should be concerned not simply with understanding the world but with applying the findings to bring about change. However, this study explored power relationships and values through the data from observation and narrative and a scholarly obligation to society (Lincoln & Guba, 1985) rather than applying an action research approach aimed at instigating change at the research sites. Critical thinking can vary from the simple rethinking of comfortable thoughts to political activism (Thomas, 1993). The aim of the dissemination of the findings from this research is to inform and influence changes in practice.

Researching My Own Field

Critical ethnography is thought to be useful to those researching their own field as it can help them to be critical of behaviour that they may view as normal or usual as an insider (Cudmore & Sundermeyer, 2007). Hunt and Symonds, in their ethnographic study of labour ward midwives in 1995, found that searching for meaning as midwives in circumstances and situations they found were familiar was difficult. Whilst practising as a clinical midwife on a labour ward, although I reflected upon practice, I do not feel that I analysed my work critically. As Thomas (1993) suggests there is a taken for granted reality that can exist about practices. We can assume that what we do is not in need of further analysis: it is accepted as the norm. Midwives, working on the labour ward may find the work all consuming with little time to spare to think about what it all means and why midwives act and react in certain ways (O'Connell & Downe, 2009, Downe, Simpson & Trafford, 2006, Hunt & Symonds 1995). However, through academic endeavour whilst working as a midwifery lecturer and being distanced from the labour ward I have been more able to reflect and recognise the hierarchical nature of practice that Kirkham (1999) describes. There were some

midwives and labour ward coordinators (LWCs) in the labour wards within which I practised who accepted their place in the hierarchy below the obstetricians and the care that they facilitated for women was in close alignment with practice guidelines and the medical philosophy of care that suggested birth was risky until proved otherwise: women were not central to their care and were expected to accept the decisions that were made on their behalf by others. These midwives often controlled the care that other midwives gave to women, rather than empowering the midwives or women to make decisions themselves.

What led these midwives and LWCs to practise in this way is unclear. However, there were some LWCs, including myself who prioritised women's wishes and appeared able to negotiate, with the obstetricians, the type of care that women wanted or that reflected a midwifery approach to care (that suggests birth is a normal physiological process that is best not disturbed). Empowering other midwives to care in the same manner was also important to me in the LWC position: it often resulted in my being able to trust the midwives to practice, rather than to oversee their care giving. Whether the difference in practices related to different values, the powerful influence of the obstetricians or the courage inherent in challenging practice and advocating for women is not clear. However, reflection on my practice experience influenced the use of a critical methodology.

Spradley (1980) warns that the more a researcher knows with regard to the research participant's world, the harder it may be to conduct an ethnographic study of it:

'The less familiar you are with a social situation, the more you are able to see the tacit cultural rules at work.'

(Spradley 1980 p.62)

Adopting a critical stance and treating the midwives as ‘anthropologically strange’ may have helped reduce the danger of taking for granted misleading preconceptions about the environment and the people in it (Hammersley & Atkinson, 2010, p.9).

Reflexivity: The Effect of the Researcher on the Study

It is apparent that a reflexive approach was a key consideration to strengthen the trustworthiness and confirmability of the research (Guba & Lincoln, 1994). By reflexivity I mean being actively involved in developing my own self-awareness to identify how my own values and opinions may impact upon on the research process and the data collected (Reed, 1995). Gough (2003) suggests that reflexivity, sits in contrast to reflection as it is more immediate, dynamic and is a form of continuous self-awareness.

Reflexivity is central to critical ethnography as it acknowledges that researchers are influenced by their sociocultural background and their personal values and beliefs (Finlay 2003). The knowledge of the researcher is as much a social construction as another (Gough, 2003). I practised as a midwife for twenty years predominantly in a labour ward environment working as a LWC prior to my appointment as a midwifery lecturer and clearly have my own views and opinions of the maternity services. This experience was the impetus that led to my decision to examine leadership on the labour ward. My own values and discourse may therefore influence the work produced.

Madison (2012, p.9) suggests that by being reflexive the researcher takes the ‘ethical responsibility for his or her own subjectivity and political perspective’. Finlay (2003) suggests reflexivity may offer more insight into personal and social experiences through engagement and subjectivity and challenges the positivistic discourse of science that advocates professional distance and objectivity. However, Gough (2003 p 31) states that the researcher should avoid being involved in ‘reflective excess’.

There should be a balance between pure description to present an objective view and a complex reflexive interpretation that is removed from the data.

Spradley (1979) also suggests that the researcher cannot avoid having an effect on the social phenomena being studied. I do not try to eliminate the effects of being a midwife on the study but to understand what the effects on the data gathering, analysis and consequent display of data may have been. Being reflexive facilitated my ability, as a researcher to reflect on my own social, cultural and professional location that could have led to making particular assumptions. Research can be viewed as a journey rather than a process (Johns 2010). As Doane (2003, p.93) suggested of herself:

‘As a researcher I have, in essence, looked for ways to be the best I can be, in terms of being sensitive to people and their experiences.’

Throughout the journey I have reflected upon the effect on the research of my own values and opinions; my experiences of the maternity services and my position as researcher and midwife. I have not only learned much about the midwives on both sites but about myself as a person and a midwife.

Walking in the Shoes of Others

“First of all,” he said, “If you can learn a simple trick, Scout, you’ll get along a lot better with all kinds of folks. You never really understand a person until you consider things from his point of view [...] until you climb into his skin and walk around in it.”

(Lee, 1989, p.39)

My experience of midwifery appeared to enhance my understanding of what midwives were doing and saying (Cudmore & Sandermeier, 2007). I understood the technical details involved in the management of different care scenarios and the context within which they were working. However, I had not practised in the environment that was unique to them. Some of the midwives sometimes assumed

that I understood what they meant by saying “you know what I mean?” and although I felt that I did know, I did not want to assume anything. I often had to suggest that I may know but I would rather hear their own interpretation and was interested in what they had to say, rather than making assumptions. I recognised the meanings and then reflected on whether they were inaccurate due to the cultural and philosophical norms I valued. I used reflexivity whilst observing, interviewing and during analysis to understand what the effect of this could be. Annechino and Ford (2011) suggest there may be value in the researcher’s previous knowledge and experience-of ‘walking in their shoes’ as it may increase awareness and insight, however, I guarded against making assumptions of having the same language and seeing the job in the same way as differences may be missed (Finlay, 2002). As Annechino and Ford (2011) suggest, it may be best if the shoes I walk in do not entirely fit to enable both insider and outsider perspectives to emerge. Cunliffe (2003) suggests that researchers co-produce rather than discover and their assumptions and activities are part of the investigation in a process that deals with complex multiple realities. If researchers view knowledge as a social and cultural construction, it would appear sensible for them to apply these principles to themselves and their own projects (Steir, 1991).

Reflecting on Power Relationships

‘If power relations are not equal between the observer and the communities of people who are affected by her truth claims, then the claims cannot be validated.’

(Carsprecken, 1996, p.90).

Employing a critical ethnographic approach meant that I constantly reflected on the power issues related to how the research was conducted and the ways in which findings were analysed and presented (Thomas, 1993). My role as either a researcher or midwifery lecturer could be viewed as powerful as the roles hold some status. Midwifery lecturers may be viewed as gatekeepers of the profession with regard to

their responsibility for passing or failing academic assessment or simply related to their teacher status. Researchers may also be viewed with suspicion. I was asked on several occasions about what I had observed and what I was observing as I made observations on both labour wards. However, I perceived this to be a result of recent managerial investigations that had occurred at both Northvalley and Springdale in relation to behaviour and attitudes. I was aware through the data collection process that both research sites had been under some surveillance in the recent past and that my research could be construed as an extension of this.

The midwives were aware through reading the research information sheet (see Appendix 5) that I was a research student but also a university lecturer who had previously practised as a midwife on the labour ward. I was aware that some midwives may see me as a senior person due to my role in the university and I tried hard to play this down to facilitate their ability to see me on equal terms. Listening carefully to what the midwives were saying and mentally noting what may need to be explored or explained later facilitated my ability to undertake the interviews. It would have been easy for me to engage in discussions with regard to practice and required a certain amount of humility to hear the midwives rather than compete with their knowledge. I feel this helped to situate me more as the researcher rather than the midwife, as Yeo, Legard, Keegan, Ward, McNaughton Nicholls, and Lewis (2013) suggest it may. However, I acknowledge the researcher's role may still hold some power.

In an attempt to allay the midwives' fears and limit any perceived power difference, I informed the midwives who participated that this was independent research with no connection to the hospital trust. I was mindful at all times that I was a visitor in their workplaces and always rang the doorbell and waited for someone to formally let me in. Choosing to sit in a position that was unobtrusive to the running of the ward, by relinquishing my seat if there were not enough for everyone to sit down, and by being

interested in whatever anyone had to say, I perceived may communicate a less powerful status for myself: it may have minimised the differences between us (Grbich, 2009). Spradley (1980) also suggests that taking the stance of a student with lots to learn: talking and becoming accepted but letting participants lead the action may also reduce the power differentials.

In addition, I demonstrated respect to the midwives by changing into labour ward uniform if requested to do so. As the midwives had to wear a uniform to comply with the hygiene policy, I thought carefully about how I dressed. I did not want to appear distinct but wanted to appear clean and tidy. I opted for casual clothes, very little jewellery and no nail varnish. Duncombe and Jessop (2002) comment that researchers learn to become aware of how they dress and appear to the interviewee to send out the appropriate signals of friendship, albeit a detached form of friendship. However, I also feel it was undertaken as mark of respect to the midwives and their working environment, although upon reflection it could have been due to my former socialisation in this rule bound environment. On one occasion the LWC suggested that I wear theatre scrubs and although I thought it may be unnecessary, as I was not going to be involved in clinical work, I acquiesced. I was comfortable in the scrubs and became invisible to a certain extent as many other midwives and doctors were wearing the same. However, I was often mistaken for a doctor or a midwife and worried that being misrepresented was unethical.

Interestingly, following my first few observations at Springdale the matron asked me how the midwives on labour ward had been which depicted them as naughty children. I voiced my concerns about my presence affecting the way the midwives behaved. She said "They [the midwives] won't care whether you are there are not. They [the midwives] will just behave as they always do...won't care whether you are there or not". "They [the midwives] don't take any notice of this" (pulling her uniform to demonstrate purple uniform denoting her position as a Matron). This suggested to

me that the midwives may be a strong group of women or did not have an effective relationship with the Matron, or both.

Ethical Approval

Ethical approval for the study was given by the School Research and Ethics Panel (SREP) within the University, in accordance with the National Research Ethics Service (see Appendix 6). NHS Research and Design approval was granted on both labour wards and a research passport gained. Access to Northvalley was granted from 12th March 2013 until 6th May 2013 primarily. However a request was made for this to be extended to facilitate the completion of the data collection. The date was subsequently extended to 30th September 2013. At Springdale access was approved from 18th December 2012 until 31st December 2015. The stages of the research were influenced by the dates, as may be expected, as there was more pressure to ensure that the data collection at Northvalley was completed prior to the deadline date for access.

Methods

The Sample

Thomas (1993) suggests that where and from whom we obtain data provides the meaning that shapes the analysis. The study was a topic centred ethnography focusing on clinical leadership and therefore a purposive sample of forty-eight labour ward midwives from two hospital NHS Trust maternity units, Springdale and Northvalley, in the North of England was employed. I recognise that generalisations cannot be made from the study of two NHS labour wards and that the idea that qualitative research has reality beyond the context in which it is located is contested. How inclusive the sample is may be important in assessing the extent to which I am able to make any representational generalisations (Lewis, Ritchie, Ormston and

Morell, 2014). However, I work toward the development of theoretical perspectives that are transferable to other midwifery areas.

I used pseudonyms for both labour wards to facilitate their anonymity and with regard to my professional rules and standards (NMC, 2012) and code (NMC, 2015a). Springdale is a district general hospital that serves the local population with a labour ward undertaking approximately 3,000 births per year. Northvalley is a tertiary centre and in addition to serving the locality, has specialist referral services that serve a wider area. Approximately 6,000 births take place annually at Northvalley. The rationale for conducting the research in two areas was to enable the difference in clinical leadership in a large and small labour ward environment, where the culture, power differentials and context of practice may differ, to be explored and give a broader view. Ritchie, Lewis, Elam, Tennant and Rahim (2014) suggest this is 'symbolic representation' (p.116) as the sample is chosen to represent and symbolise characteristics that are necessary to meet the aims of the research. A sample chosen because it has particular features facilitates a detailed examination and understanding of the central themes within it. This differs from quantitative research that is concerned with statistical representation by employing a random sample to support being able to generalise the findings. However, both are concerned that findings are attributable to the study.

Observation Schedule

The primary concern in qualitative research is what to observe and how many observations, interviews are necessary to convince the researcher that his/her findings will provide useful data (Luborsky & Rubinstein, 1995, p.1).

I visited both labour wards for four hours initially (which reflected the time I had available in my diary) to arrange the dates and times I was able to undertake the observation. These initial visits gave me an overview of the ward routines and layout.

Silverman (2014, p.247) suggests this is 'casing the joint' as it helped me to decide where I may be able to position myself and where and what type of activity was taking place that I would want to observe. The dates and times of my visits to both Northvalley and Springdale were recorded in the ward diary so that the midwives on duty knew when I would be observing. This meant that any midwife who did not want to be observed may be able to arrange her off duty around the planned dates and times, although I am not aware that any of the midwives did this.

I was aware that prior knowledge of my visit could have affected the behaviour of the midwives. However, they were more often surprised by my presence. I attended during the handover of care from one shift to another; at different times of the day (morning, afternoon and night); different days of the week and when different midwives were available (see Appendix 7). Being present at various times can disrupt the tendency for unnoticed biases that may influence the recording of preliminary data and should catch the effects of time and organisational routine on interactions (Carspecken, 1996). However, I was also aware that recurrently observing at particular times, such as at handover may facilitate the capture of regular patterns of behaviour. As Spradley (1980) suggests, what is observed needs to be tested repeatedly until sure this is a shared cultural meaning. I observed for two hourly periods as longer periods may cause burnout (Carsprecken, 2006) and it may not be feasible to capture or recall everything that is observed over long periods of time. This amount of time facilitated the capture of the longer ward routines, such as the handover of care and medical ward round. McNaughton Nicholls et al (2014, p 256) suggest that the 'time frame for observation should include a rounded set of observations that are pertinent to the questions asked by the research'.

Interviews

There are a number of midwives who practise on labour wards with a range of experience and knowledge. I aimed to undertake preliminary interviews with four

midwives on both labour wards from each pay banding. It was anticipated that this number may reflect the diversity of the midwives so that the difference in their perspectives could be explored. Ritchie et al. (2014) suggest that the heterogeneity of the sample may lead the researcher to increase the sample size to capture the diversity within it.

Luborsky and Rubinstein (1995, p.5) suggest that in qualitative research:

‘the nature of the units and their character cannot be specified ahead of time, but are to be discovered, the exact number and appropriate techniques for sampling cannot be stated at the design stage, but must emerge during the process of conducting the research.’

I aimed to interview four midwives of each pay banding, however, during the fieldwork there were some midwives that came forward and were available to interview when I visited the labour ward whilst I was waiting to interview others. I believed I could not ethically refuse to interview them. This can be seen in the numbers of Band 6 Midwives at Northvalley and the number of Band 7 Midwives at Springdale (see Tables 2 and 3 on p.96 and p.97). Whilst I am aware it is customary to write numbers below ten in full, I refer to the numeral when it refers to the pay banding as it is associated with a midwifery title.

Although I have had to remove myself to what Hammersley and Atkinson (2010, p 90) describe as a ‘social and intellectual distance’ from the midwives I tried hard to ensure that I recognised the midwives as people and not just as research subjects or objects within the thesis through the use of appropriate language (Letherby, 2003). Whilst the pay banding, ranking system helped me to determine the sample of midwives, it also raised questions with regard to regimentation and power. Prior to undertaking the research I had not really appreciated the extent of the hierarchy and ranking system that objectifies the midwives in terms of pay scales or economic

worth. Foucault (1980) suggests that hospitals were borne out of discipline as a means of creating a functionally useful place where care could be given and controlled. He also suggested that discipline is an art of rank where people are individualised by their location in a network of relations in a hierarchy.

The use of the title 'Band' was, and still is, generally how most midwives refer to themselves and one another, which suggests a hierarchical discourse existed that appeared to be accepted. However, a midwife whom I interviewed (Gina B72N) appeared to resent referring to midwives according to their banding. She suggested a Band 6 Midwife, although paid more than a Band 5 midwife may not be as skilful as the Band 5 Midwife. I attempted to use the terms 'newly qualified', more 'senior/experienced' midwives and midwives with some degree of managerial responsibility throughout the thesis, however, referring to the midwives in this way appeared confusing and became unwieldy. What I did was to continue to use the pay bandings to refer to the midwives but acknowledge my reservations and discomfort in doing so.

Thirty midwives were interviewed primarily (see Table 2) and as part of the interview were invited to nominate a midwife they suggested was an 'effective' clinical leader on labour ward and describe their characteristics.

Table 2: Number of Preliminary Interviews at Springdale and Northvalley

Midwives (n=30)	Springdale	Northvalley
Band 5	4	4
Newly Qualified	2	2
1-2 years post qualification	2	2
Band 6	4	7
Less Experienced	3 (2 - 3 years)	4 (4 to 6 years)
Experienced	1 (22 years)	3 (11-16 years)
Band 7	5	4
Experienced midwives	2 (10-20 years as a Band 7)	3 (8-10 years as a band 7)
In an 'Acting' Role	1	0
Newly Appointed	2	1
Band 8	1 (Matron)	1 (Consultant Midwife)
Total Number Interviewed	(n=14)	(n=16)

Twenty-one midwives were nominated and eighteen were interviewed (see Table 3). I was unable to interview two of the Band 6 midwives who were nominated as 'effective' clinical leaders at Northvalley and one at Springdale as one was on long term sick leave, and two had left the Trust to work elsewhere. Being unable to interview these Band 6 Midwives led to a lower representation of these midwives, although they were small in number, within the data that may have impacted the findings.

Table 3: Number of Interviews with Midwives Nominated as 'Effective' Clinical Leaders

Nominated Midwives (n=21)	Springdale	Northvalley
Band 6	1 (unavailable for interview)	4 (2 unavailable for interview)
Practising on Birth Centre	N/A	1 of the 4
Band 7	8	7
Practising on Birth Centre	N/A	2 of the 7
In an 'Acting' Role	1 of the 8	0
Newly appointed	0	0
Band 8	0	1 (Matron)
Total Number Interviewed	(n=8)	(n=10)

I had not intended to include the midwives practising on the along-side birth centre at Northvalley at the outset, as I wanted to focus on the labour wards that may be inherently different (Walsh, 2006, Deery et al., 2010). However, as the midwives rotated between both labour ward and the birth centre it appeared logical that they may have experienced clinical leadership on the labour ward. Women who used the services were not involved in the study, however, prior to the commencement of the study a discussion with the research ethics coordinator clarified that should this have been necessary, consent should be obtained to enter rooms to observe the midwives.

Representation

Representation relates to how researchers describe their participants and data and is important in critical ethnography. How we represent the people we study reflects the researcher's position in relation to them. Cosgtagno (2012) suggests there are three stances that may be taken: that of the ventriloquist, where the researcher is detached and descriptive, using the participants' voices where the researcher is present but the role is not clear or one as activist who advocates and takes a stand

against injustice. I chose to take the activist stance as this appears to be more relevant to critical ethnography but to ensure that the findings emanate from what the midwives said. Letherby (2003) suggests that fully representing the people involved in research can be affected by the selection of the methods employed, the explanations, interpretation and judgements made. She suggests that the researcher should take care not to generalise the subjective accounts of those involved so that they are no longer recognisable.

The midwives at Springdale spoke with a strong northern accent. When I first commenced transcribing the observations and interviews I decided that I wanted to remain true to the dialect as it reflected their identities. However, on re-reading the transcripts they were unclear. I understood the dialect but others may not have. Grbich (2009) suggests that having a clear sense of what people say may be better than the meticulous recording of someone's 'less than perfect' English as the latter can appear to belittle them. I concur and feel that being true to their accent may also have revealed their identity. The midwives in the study were all female and will be referred to as such. However, I acknowledge that midwifery, whilst being a predominantly female occupation, does not preclude men.

Anonymity

Bryman (2016) suggests that prevention of harm is addressed by ensuring identities and records of individuals are marked as confidential. However, this may not totally eliminate the possibility of identification, as occasionally behaviour may be related to particular individuals. Data pertaining to specific places or people should be dealt with sensitively to ensure that anonymity is assured (Madison, 2012). Place names were protected by using pseudonyms to refer to both labour wards and being Northern rather relating to a particular NHS Trust. The identity of individual midwives may be protected by carrying out the research on two labour wards, although the differences between them may be apparent.

The midwives were anonymised throughout the analysis by attaching pseudonyms in place of their names, **B** followed by the particular number that represented the midwives pay banding e.g. **B5**, **B6**, **B7** or **B8**. The number **1** represents **Springdale** labour ward and the number **2** represents **Northvalley**.

- ‘Selma (**B51**)’ represents a midwife given the pseudonym Selma who is a **Band 5** Midwife at **Springdale** (labour ward **1**)
- ‘Donna (**B7N2**)’ represents a midwife given the pseudonym Donna who is a **Band 7** midwife **Nominated** as an effective clinical leader at **Northvalley** (labour ward **2**).

I was the only person aware of the relationship between the names, numbers and pseudonyms. The midwives who participated in the research were aware that the data was securely stored and that all the audio recordings would be destroyed following data analysis in line with ethical approval (British Sociological Association (BSA), 2002). I felt uncomfortable about using only alphabetical or numerical terms as forms of identity as it appeared to objectify the midwives and therefore pseudonyms were also given to the midwives as a means of recognising them as people at the same time as protecting their identities.

Gaining Access to Labour Ward

Hammersley and Atkinson (2010) suggest that negotiating access can generate important knowledge regarding the field. I first met with the heads of midwifery (HOMs) on each site to introduce myself, the research, to discuss my access to the labour wards and to facilitate the distribution of information with regard to my study. Both HOMs were happy to see me and interested in the study but appeared to be worried about the reception I may receive from the senior midwives on the labour ward. As I suggested earlier in the chapter (p.91) the HOM at Springdale suggested that the midwives were strong, vocal women and may not be welcoming. The HOM

at Northvalley reiterated the same and also suggested that the midwives may feel that they were being exposed to surveillance related to some work regarding improving behaviours that had recently taken place in the maternity service. This information made me feel quite anxious with regard to whether or not I would be able to recruit the sample. As I have already suggested the midwives may be suspicious that the research was another form of surveillance that may be seen as a source of power (Foucault, 1976). Letherby (2003) suggests research that involves gaining access through gatekeepers can make those involved worry that the information they proffer may be accessed by the gatekeepers and potentially used against them.

In an attempt to distance my research from the suspicions of the midwives I often reassured the midwives that my research was independent of any local strategies to enhance behaviours. Jewkes and Letherby (2001) employed this strategy to distance themselves from an association with the Home Office and prison services when conducting research in a prison. I had not been employed in either of the hospitals where the research took place, however, I did know one of the midwives superficially through my role as a supervisor of midwives and three others through my involvement in their midwifery education. When I encountered these midwives it often made my presence appear more welcome as they were obviously familiar, hugging me or introducing me to their colleagues. The familiarity of the midwives appeared to facilitate my access to both labour wards on two or three occasions and as a result the senior midwives appeared more willing to free someone from their work to be interviewed. However, I was uneasy as I perceived my acceptance by these midwives may manipulate a vicarious, positive perception of me by other staff, although it facilitated my engagement. This ease of engagement has been reported by other researchers (Allen, 2004 & Simmons, 2007). Gaining access can be a full-time, time-consuming occupation (Webster, Lewis & Brown, 2014, Carsprecken, 1996, Spradley, 1980).

I visited Springdale and Northvalley on two occasions prior to data collection to speak to midwives about the research and the observations and interviews I wanted them to be involved in. I found places where I could undertake interviews and became familiar with the layout of the unit and labour ward: the off duty and requested access to guidelines and policies that may give me some insight into the practices on labour ward. As there would be other clinicians in the clinical area an information sheet was provided to inform them of the proposed research (see Appendix 5). Participant information sheets (see Appendix 8) were distributed by the heads of midwifery to the midwives via their work post boxes and information sheets were distributed in the staff rooms and offices.

My experience of preparing to enter the field highlighted the relational nature of the research. I perceived that I needed to engage in good relationships with the HOM, matron and midwives and be sensitive to their needs as they may gate-keep the labour wards, and had the potential to make my presence either comfortable or uncomfortable. Hammersley and Atkinson (2010) suggest that the relationships we forge with potential gatekeepers or supporters can have significant consequences for the research process. They have the potential to block certain avenues of enquiry and I wanted them to be involved in the research. With this in mind I was careful not to pressure the HOM, who had been on leave, with regard to starting the data collection (that I was very eager to do). I did not want her to believe I was oblivious of the demands on her time and that I was a priority. I did the same with the matron who had some family health issue and I therefore delayed seeing her so that she did not have too much to consider. This appeared to be to the detriment of getting started. However, I perceived the respect I showed was reciprocated through the access and support the midwives gave me.

Only one midwife contacted me by telephone to say that she would be happy to be interviewed outside of work time. This meant that I arranged to visit each labour ward

regularly in the hope that there would be a midwife available and who consented to be interviewed. To gain access to both labour wards I had to ring the outside bell and either a midwife or a ward clerk opened the door. I was then directed to the midwife in charge of the shift who was the LWC. The LWC allocates the midwives on the shift she is coordinating to care for the women who are present on labour ward. She is therefore aware of which midwife could be freed or was available to be interviewed. The LWCs control over who may be accessible raised some ethical issues in that the midwives who the LWC felt were available may have felt coerced to speak to me (Lewis et al. 2014). To minimise this effect I discussed the research participant information (see Appendix 8) and the consent form (see Appendix 9) carefully with the midwives to ensure they were happy to continue and I made it clear that I could wait for someone else to become available if they preferred not to take part.

There were occasions when I visited the labour wards when the LWC appeared tired and exasperated at the sight of me due to the busy labour ward environment. It appeared that I was one more person for her to accommodate. There were four such occasions when this occurred and I either asked if I could do some observation or left and arranged to call at another time. I feel that this cemented some kind of relationship and mutual respect between myself and those particular LWCs that facilitated my integration as a researcher. My own interpersonal skills that have developed over many years in midwifery practice and education appeared to facilitate gaining access to labour ward. At Springdale I encountered a particular LWC who had been informed that I was present. She walked quickly past me and muttered under her breath, 'I'm not going to be interviewed'. I saw her on the corridor later in the day and said that I hoped she would be able to contribute to the research as I valued her contribution. The LWC smiled and was subsequently interviewed as one of the nominated clinical leaders. I perceive that had I not, (although I may never know), approached her when I did she may have been less inclined to be interviewed.

Hammersley and Atkinson (2010) suggest that gaining access is a practical matter that requires the researcher to use many of the interpersonal skills we use in daily life. The aim appears to be to develop relationships whilst at the same time ensuring the relationship does not affect the ability to be analytical.

Data Collection

Data collection took place over a period of nine months, commencing at Springdale on 12th February 2013 and on 2nd July 2013 in Northvalley due to a slight delay in gaining ethical approval. The process was constrained by the extent to which the labour wards were busy, as it either facilitated or hindered the freeing of midwives to be interviewed and my own availability and that of the nominated midwives coinciding. Observation and interviews were completed on 17th October 2013. The schedule for the research process at Northvalley and Springdale can be found in Appendix 10.

Being in the Field

Observation

Observation was employed to uncover power relationships, clinical leadership characteristics and the discourse within the labour wards. Observation is important as to make cultural inferences there is a requirement to see what is done, heard and used. Research participants know things they are unable to articulate (Spradley, 1980) and therefore observation can be useful to uncover this. However, Bourdieu (1989, p.16) suggests that:

‘The truth of the interaction is never entirely to be found within the interaction as it avails itself for observation.’

(Bourdieu, 1989, p.16)

A combination of observation and interviews were therefore employed to corroborate or explain what was seen and to facilitate diverse interpretations of the same activity.

Bryman (2016) suggests that the triangulation of the methods used to collect data enhances the dependability of the findings. McNaughton Nicholls et al. (2014) suggest that both interpretations are valid and together may produce a multifaceted account of what has been observed without giving precedence to only one.

Gaining Consent

Informed consent requires the researcher to assume the responsibility to explain comprehensively, in terms that the participants understand, what the research is about: who is undertaking it; why it is being undertaken and how it will be disseminated (BSA, 2002). Participant Information sheets (see Appendix 8) and information regarding the days and times I would be present were made available in advance so that midwives were aware when I would be observing. The obtaining of informed consent from the midwives in the clinical environment whilst undertaking non-participant observation was difficult. Hammersley and Atkinson (2010) suggest that even when it is made apparent that research will be taking place, informants may forget as they come to know the ethnographer as a person. They also suggest that continually informing informants of the reason for the researcher's presence or giving people the opportunity to decline to be observed can be disruptive or even impossible. Consent for observation was taken on the day of the observation. This caused some difficulty as it focused the midwives on my presence. However, at Springdale I was unsure how to avoid not being the focus of some curiosity and attention in a small space. It did provide an opportunity to discuss the research with the midwives and answer any questions they may have had. McNaughton Nicholls et al. (2014) suggest that in some studies, as in this, it may not be possible to know who will be present and to inform them in advance.

Non-Participant Observation

Non-participant/passive observation took place on both labour wards using a flexible observation schedule so that a broad range of activity could be observed. The

premise for this decision was to capture what was observed whilst minimising my presence affecting what was observed (McNaughton Nicholls et al., 2014). Conducting non-participant observation with members of your own profession can be challenging through the tension that exists between being known to a certain extent, as an insider and observing through an outsider lens (Allen, 2004). Debate continues as to whether the best research is undertaken through outsider or insider observers. However, Hammersley and Atkinson (2010) suggest that although complete observation can minimise the problems of reactivity, it involves the researcher being visibly present and therefore even if not participating, there may still be a possibility that their presence could affect what is happening (McNeill and Chapman, 2005). Social research can be viewed as participant observation as regardless of the researcher's role, she or he participates in the social world and reflects on the findings of that participation (Hammersley & Atkinson, 2010).

Being non-participatory may be viewed as the researcher having little emotional involvement with the participants. However my previous experience of working as a midwife meant that I had some emotional attachment to my profession. Spradley (1980) suggests one can hardly be a complete participant and ethnographer but must be both insider and outsider: to understand it from the native's view and learn from people rather than study them. Burns, Fenwick, Schmied and Sheehan concur stating that:

‘The challenge for midwifery researchers observing practice is to balance their positionality within the middle ground with ethical integrity, authenticity and rationality. The moral and ethical challenges which arise as part of the observational experience should be viewed as opportunities for reflexivity and exploration of the subjective positioning of the midwife observer.’

(Burns et al., 2012, p 59)

What to Observe

Some selection of what to observe was made: as Hammersley and Atkinson (2010, p.144) suggest, ‘one can never record everything: social sciences are truly

inexhaustible in this sense'. However, it appeared evident and appropriate to observe the central location on both labour wards that consisted of the office in which the midwives congregated and where the LWCs, who were in charge of the shift, were located. I also moved my position around the outskirts of the ward and the office to have a different perspective. I spent a great deal of time waiting for midwives to become available for interview in the sitting rooms, empty labour rooms, the birth centre reception and offices. These occasions proved valuable for gaining a comprehensive record of activity.

Spradley's (1980, p.78) grand tour observations facilitated the planning of what I intended to observe. I observed the physical spaces, such as the central office on the labour ward. The staff office was a place where a thick record was compiled as it was the hub of activity on labour ward and where the midwives wrote their notes, spoke to doctors, handed over women's care and generally congregated. The actors and their activity were observed alongside the physical things that were in the environment, such as the white boards that were continually updated and referred to denote the activity on the labour ward. Particular acts, such as the handover of women's care from one group of midwives to another or from midwife to obstetrician, sets of related activities, such as the allocation of work following handover and the sequencing of actions that took place over time were also observed. I also noted the body language that was expressed by the midwives.

I completed 'mini tour' (Spradley, 1980, p.79) observations to examine smaller units of experience, such as the observation of particular midwives whilst they coordinated care during a busy shift of midwives. The mini tour observations were made as a result of drawing on specific information I had previously discovered through observation and reflection. I did not observe the interaction between the midwives in the rooms where women were being cared for as I felt that this would be intrusive for the women and their families. However, I acknowledge that had I observed some of

the interactions between the midwives whilst giving care it may have supplemented the findings. Interactions and decision-making between women, midwives and obstetricians may have highlighted leadership practices. Feedback, analysis and reflection on the observation gave direction to the research and facilitated open-ended enquiry (Carsprecken, 1996). It also made writing part of the cycle.

Unobtrusiveness

Bryman (2016) suggests that observing an unfamiliar setting facilitates the researcher to observe without any preconceived ideas about the environment. However, this also means that time must be spent gaining understanding of the environment within which the midwives worked. General descriptive observation of the labour ward environment was undertaken on two occasions in each site prior to data collection so that the staff became familiar with my presence. It simultaneously helped me to become familiar with the environments and was done with the intention of reducing the effect I may have on the behaviour of the midwives. Unobtrusiveness may confer some advantages for the researcher (Spradley, 1980). Being a passive observer over time may have reduced the effect I had on the environment. This appears to be borne out by the changes that occurred. During the preliminary observation on both labour wards I found myself introducing myself and the research but in the later stages the midwives appeared to be more aware and interested in how the research was proceeding and had become familiar with my presence.

I was concerned with regard to the effect I had upon the routine activities on both labour wards as I chose to observe primarily in what appeared to be the hub of all activity, the central office. Both offices were very small and therefore it was difficult to remain out of the midwives' line of sight, which was a strategy that I employed to reduce the effect of my physical presence. My initial observations at Springdale found the ward quiet. This appeared to highlight my presence, due to the increased number of chairs needed to accommodate the midwives and my self-relegation to a seat on

the window sill. However, when the ward was busy I often felt my presence keenly as I was often sitting near to a phone that was ringing continuously and was unable to answer it. When midwives came in to answer the phone they had usually had to leave something else to do so, they often glanced at me. I had to remind myself that I was there in a researcher capacity and not as a midwife. If there was anything I could do, such as move some cups to the kitchen I did this. I am not sure if this made me feel better or whether the midwives were grateful. Deery (2003), Hunt and Symonds (1995) found the same tensions observing in a busy labour ward and helped to make beds and answer telephone calls to resolve the dilemma of remaining a researcher or alienating the midwives.

To mitigate the effect of my presence I tried to arrive early to avoid having introductions in the midst of handover that may have disrupted the natural flow of behaviour. I also avoided joining the midwives for their break at first as I felt this was respite for them from me. I did not want to engage in any more depth or in personal chat as I felt it may compromise my interpretation of the situation. After several observations I felt it was impossible not to engage in some way with the midwives. I visited Northvalley and Springdale on many occasions that required introducing myself to those I had not met before, gaining consent for observation and being able to clarify any activity that I was unclear of. However, Carsprecken (1996) suggests that alterations in behaviour brought about by the presence of the researcher do not usually lead to changes in the cultural milieu.

Making Fieldnotes

Ethnographers should document their fieldnotes in a manner that accurately portray and preserve local meaning (Emerson, Fretz & Shaw, 1995). However, writing observational fieldnotes was complex. My close physical proximity to the midwives meant that I perceived I could not use a note pad and pen to record my observations contemporaneously for fear of affecting any activity or discussion. Emerson et al.

(1995, p 14) suggest if fieldnotes are immediately written they capture sharp distinct qualities and features regarding the environment that on re-examination capture a vivid picture for the researcher. This was a compromise I was willing to make as I did not want the midwives to feel uncomfortable and to view myself as being the all-seeing, controlling 'Panoptican' (Foucault, 1991, p.200) However, I then worried about not recording what was happening verbatim and contemporaneously capturing this. To overcome this I tried to limit the observation periods to two hours and then wrote my notes as soon as possible after the event. If I perceived that something I had heard or seen appeared to be significant I left the area and wrote this up straight away. This helped me to record some conversations verbatim. To facilitate the accurate recall of the observations I made, I wrote them up as soon as possible after the event. This occurred either in the car park or when I arrived home. It was more complex to capture conversations and I had to relay what I remembered. Carsprecken (1996) appeared to have the same difficulty in his TRUST Study.

Writing up the observation was more difficult than I anticipated. It seemed very facile to slip into analysis or assumption rather than recording facts. It was easy to say the midwives were happy as I assumed smiling and singing reflected this. I soon realised that I had to record pure factual observation and that my own thoughts and feelings were dealt with separately within the record. Concrete facts that are seen and heard should be used when recording observations and in as much detail as possible to avoid generalising (Spradley, 1980, p.68). This can avoid the difficulty associated with making generalisations from generalisations later in the research process. Letherby et al. (2013 p.219) state the important question is what can be said about the 'truth' of the statements we make about observations and the accounts we give of them. The primary record should represent what took place in a manner that any observer or participant would repeat under ideal conditions (Carsprecken, 1996). Discussing the difficulty with my academic supervisors was also helpful in clarifying

the way forward and was in line with the BSA (2002) Statement of Ethical Practice to recognise my professional competence and request assistance when required.

Interviews

Alongside observation, in-depth, preliminary, semi-structured interviews were undertaken with thirty midwives (see Tables 2 and 3 on p.96 and p.97 for details of the sample). The preliminary interviews were conducted as a means of exploring who the clinical leaders were perceived to be, the characteristics and discourse associated with their clinical leadership and the power relationships that existed.

There appears to be some debate as to the involvement of the researcher in the generation of data within the interview process: whether data is something that exists prior to the interview or is constructed within it. I share Yeo et al's pragmatic view that:

‘A research interview is an interaction between participant and researcher and this interaction will shape the form and feature of the data generated.’

(Yeo et al. 2014, p.180)

Ethnographic interviewing is assumed to be unstructured and flexible to facilitate conversation that flows naturally and allows for exploration (Grbich, 2009). This may also equalise the power dimensions between the interviewee and interviewer by being less constrained. However Hammersley and Atkinson (2010) suggest that interviews similar to any other kind of social interaction are structured both by the researcher and interviewee and whilst ethnographers may not ask each interviewee the same questions they will generally have considered the issues to be covered before they start so that they meet the requirements of the research agenda. Interview guides (see Appendix 11 and 12 for interview topic guides) were used to facilitate the coverage of the salient points and to meet the aim and objectives of the research.

Brewer (2002, p.63) suggests that interviewing is based on a couple of assumptions: that the interviewee's verbal descriptions are a reliable indicator of their behaviour, meanings, attitudes and feelings and that the questions represent the subject of the research. Brewer (2002) also suggests that these assumptions may be challenged by other forms of data collection that go beyond verbal accounts to actual behaviour, such as participant observation. Interviews can offer opportunities for insight (Thomas, 1993) through information that contradicts what has been observed or vice-versa and may indicate potential cover-ups.

Access and Availability

The nature of practising on a labour ward meant that the ward was frequently busy and the midwives were consigned by the LWC to care for the women who were present on labour ward on her shift. Being free to be interviewed was reliant upon which woman the midwife was caring for (whether she was not in labour, in early or established labour or had given birth) and whether the LWC felt she could be freed. The situation appeared to give the LWC some control over who was interviewed but only with regard to who was free and when. However, there were no days when all the midwives were free for her to be able to have chosen who she thought I should interview. There were a couple of occasions where I left both labour wards because they were extremely busy as I did not wish to become of any concern. The busy ward and the banding of the midwife I wished to interview also drove the process. What appeared most important was that the midwives did not feel coerced.

Informed Consent

Prior to the interview and signing of the consent form the midwives were given the participant information sheet that had previously been distributed to read (see Appendix 8). Written consent was given by every midwife and it was made clear that there was no obligation to take part in the study or any penalty for declining to participate (see Appendix 9). However, the midwives were aware that any data that

had been collected prior to their withdrawal may be used. I did suggest that I was interested in what they thought about clinical leadership and valued their input. I made it clear if the midwives were hesitant about disclosing information that they were not obliged to and that what was said would be confidential or anonymous.

Conducting the Interviews

The role of the interviewer may be vital to facilitating the interviewee to be open and at ease, although McNeill and Chapman (2005) state that interviewers have to be 'friendly but restrained' (p.51) to encourage them to be frank and truthful and avoid them trying too hard to please. However, Letherby (2003, p.82) suggests that this may be a means of 'socialising the interviewer and interviewee into the correct behaviour' to facilitate the collection of objective data from the interview. Weber (1997) suggests that objective truth is something that is unavailable to a human theorist and that he did not claim to know the truth, merely his own version of it. Subjectivity means objectively reporting on the subjectivity of subjects (Thomas, 1993). Letherby et al. (2013, p.153) posit that the researcher should start with the subjective and theorise on it when considering objectivity and subjectivity. Letherby et al. (2013) suggest:

'As social research involves individuals who are socially situated, 'theorised subjectivity' acknowledges that research is subjective, power-laden, emotional, embodied experience, and considers the positive and negative aspects of this. Starting with subjectivity though does not mean that we give in to the subjective, indulging our subjectivities. Rather, it requires the constant, critical interrogation of our personhood within the knowledge production process.'

(Letherby et al., 2013, p.153)

The most effective way to find out about others' lives is through non-hierarchical relationships, where the researcher invests something of themselves by responding to questions or sharing knowledge (Oakley, 1981). The NMC (2015a) Code that sets out the principles by which midwives practice is reflective of what Oakley (1981) suggests and therefore my professional integrity was assured to some degree by

behaving in a respectful manner when engaging with others. The BSA (2002) Statement of Ethical Practice suggests that researchers should ensure professional integrity, prevent harm to research participants and others that may be involved.

Relationships and Rapport

I anticipated that the midwives may be resistant to speaking to me or giving me access to their worlds. In retrospect I need not have worried. Contrary to what I anticipated, I encountered women who freely disclosed what I perceived to be sensitive information with regard to relationships with doctors and each other and the maternity services. Women may be seen as 'good' interviewers because of their roles as nurturers, emotional labourers and communicators (Letherby, 2003). Oakley (1981) also argues that feminist researchers and their female research participants are both insiders in the same culture: the narrowness of the social distance between them means that the basis for an equal, two-way, emotionally empathetic approach exists and supports intimacy. However, Phoenix (1994) suggests that shared womanhood may not be able to compensate for differences, such as social class, ethnicity and sexual orientation. The association of being a woman and a good listener is dismissive of the emotional, labour intensive work associated with both male and female researchers (Letherby, 2003) and may be viewed as sexist.

I am unsure whether these were the reasons why the midwives were frank and open with regard to their experiences or whether they were not listened to or supported in other arenas. One particular midwife spoke to me for an hour and twenty-five minutes about several episodes of profound loss she had experienced and her attempts to deal with it. She cried intermittently throughout our conversation, and although I asked if she wanted to stop several times, she wanted to continue. I suspect that my long experience as a midwife and an educator facilitated my ability to listen to her. However, this may have enhanced my ability to establish close personal rapport with this midwife that became therapeutic (Rossetto, 2014).

When rapport is perceived as being deep interviewees may be more apt to discuss more intimate emotions and experiences (Duncombe & Jessop, 2002). They may also regret that they have done this at a later date. I was aware that what the midwife was saying may not be entirely relevant for my research but sensed that she needed me to listen to her and I did. I reflected on the interview and was aware that, although much of what had been said would not be used in the thesis, my responsibility for the midwife, as a fellow professional, another human being and my integrity as a researcher had been met through my response to her. Reflexivity with regard to the interview process can highlight any effect of the relationship on the data collected (Finlay & Gough, 2003).

Duncombe and Jessop (2002, p 3) suggest that rapport and gaining trust can be purposefully developed in qualitative interviewing to facilitate the accumulation of research data, rather than friendly interviewing to facilitate a participatory approach. Whilst I recognise my own attempt as a researcher to purposefully develop, I consider that although a research interview requires a friendly approach to facilitate engagement, it is not a friendly conversation. As Spradley (1980, p.59) suggests, the interview 'contains an explicit purpose, explanations and questions'. Duncombe and Jessop (2002, p.6) also suggest fake rapport creates the potential for the hidden use of power relationships in the interview process, as well as leading to degree of 'ethical naivety' if this is unacknowledged. Although I was aware that I needed to develop relationships with the midwives on both labour wards to facilitate the accumulation of data, I did so with the conviction that I have when I encounter any other person: I strive to be approachable and treat others with respect.

However, there was a particular interview with a senior midwife that left me feeling rather uncomfortable. I found myself as Jessop (2002) did when discussing her own research, sensing that I was nodding and smiling and appearing to agree with views that I opposed but at the same time thinking this is rich data. It felt dishonest but I am

not sure how I could have reacted differently. The midwife also asked me to turn off the tape as she did not want some of the things she said to be recorded, which as in Jessop's (2002, p.13) experience, appeared to invite my 'collusion' in concealing what she had to say about other midwives from being exposed. At the time it also seemed very tempting to use the data. Duncombe and Jessop (2002) suggest researchers face ethical dilemmas of striking a balance between the potential for emotionally adverse consequences for the person, as a consequence of being interviewed, against the more ephemeral gains that are made through the research, such as the enhancement of public knowledge. This relationship building made me reflect on the subjective nature of research and the tension of being objective and non-participatory and how important reflection would be to reveal what effect I may have on the research. It made me consider how difficult it could be to write frankly and honestly about a group of people with whom I had developed a relationship and the importance of honesty and transparency regarding the process.

Recording Interviews

The midwives chose the place where they wanted to be interviewed and often chose to sit by my side which I perceived to be more informal. The midwives' proximity was occasionally hampered by the use of a digital recorder that needed to be placed on an available surface between myself and the midwife to capture the interviews. Every midwife consented for the interview to be recorded on the premise that these would be stored securely in the university, anonymised to ensure their confidentiality and destroyed within five years of the completion of the research. Recording was important to the midwives, myself and the credibility of the findings, as I may not have been able to represent what we had spoken about accurately had I to rely on my memory.

As the interviews progressed I became more comfortable with the process. I asked more concise and clear questions and interrupted less often. My increasing skills and

confidence appeared to facilitate the midwives' engagement with and response to the questions (Yeo et al., 2013). To reduce the possibility of missing an issue that may have been important to the midwives I asked everyone near to the end of the interview if there was anything that we had not covered or that was important for them that they would like to discuss. I viewed this practice as a means of facilitating the full participation and empowerment of the midwives and to cover something I may have over looked. However, I cannot be sure that this was the result.

Nominated Clinical Leaders

Towards the end of the preliminary interviews I asked the midwives to identify those midwives who they perceived were effective clinical leaders on the labour ward, so that I could subsequently interview them. Whilst I recognise that this request may have limited the data to include only positive clinical leadership on the labour ward, the midwives also highlighted negative clinical leadership behaviour. Byrom and Downe's (2008) study also explored midwives' accounts of 'good' midwifery and 'good' leadership and like them, I did not stipulate what 'effective' clinical leadership represented. The midwives were at liberty to articulate what 'effective' meant to them.

I deliberated with regard to the ethics of asking the midwives to identify a clinical leader to be interviewed and whether it placed them in a vulnerable position. However, no one but myself was aware who had nominated the 'effective' clinical leaders. In 2006 David Stanley gained ethical approval from his academic institution and the NHS to ask nurses to do the same thing. I did not encounter any obstacles with the School Research Ethics Panel (SREP) in the university and an Integrated Research Application System (IRAS) was not required for the research. Identifying midwives as clinical leaders may benefit those midwives as it may be viewed as an accolade and may prove to be motivational rather than harmful. This was borne out by the often surprised and pleased reaction of the midwives who were nominated. Most of the midwives did not hesitate to nominate someone. However, there were

some misgivings when two midwives were asked to nominate an effective clinical leader, as they were not sure if they were allowed to do this or whether the person they nominated would want to be interviewed. In an attempt to reassure the midwives they were informed that they did not have to identify anyone and should they nominate someone, this person need not participate in the interview process.

The second phase of interviewing began whilst the first phase was in progress due to the time available to me and the dates of access. All the clinical leaders identified by the midwives in the preliminary interviews were contacted and asked if they could be interviewed. I examined the off duty rotas to find out when they were working and either rang or called to arrange a time that we could meet. This happened through convenience as the majority of the nominated midwives were LWCs and found it difficult to allocate time for me due to their responsibilities on the labour ward. Twenty-one midwives were nominated and eighteen were interviewed (see Table 3 on p.97 for details of sample).

Interpretation

Analysis in Qualitative Research

The aim of analysis is to portray and explain the social worlds of people under study (Spencer, Ritchie, Ormston, O'Connor & Barnard, 2014). There appears to be no concise formula for the process of analysing ethnographic detail (Hammersley & Atkinson, 2010). Until the last decade qualitative data analysis has been a relatively neglected area, in terms of research texts and research accounts of specific studies (Mauthner & Doucet, 1998). Costagno (2012) suggests that the data analysis of critical ethnography follows techniques similar to those of other qualitative research, such as coding, developing themes, asking questions, making comparisons and searching for patterns and negative cases.

Analysis in ethnography is not a particular stage in the research. Hammersley and Atkinson (2010, p158) suggest that analysis starts with the clarification of the research question, proceeds through analytical notes, memos and informally through ideas and hunches. Analysis commenced at an early stage through the observation. Reflecting on what had been observed gave direction to what would subsequently be observed and instigated some of the questions that were posed at interview to clarify what had been observed. At Springdale I had noticed that I rarely saw the doctors and I asked for clarification of this at interview. Particular interview data often prompted me to enquire if other midwives had the same views regarding their thoughts about working on labour ward.

Primary Analysis

Immersion

What seemed apparent primarily was that I needed to become familiar with the data.

‘Underpinning the process of analysis is the necessity to know one’s data.’

(Hammersley & Atkinson, 2010, p.162)

Familiarisation ensures that the codes or themes that are developed are grounded in the data (Spencer et al., 2014). Carsprecken (1996) suggests that the more familiar the researcher is with the culture of the participants the closer their interpretations are likely to be with what the participants report themselves. Writing up my observations and transcribing most of the interviews and checking the transcriptions I had not completed enhanced my familiarity with the data. Attaching preliminary codes or indexing also had the same effect.

The early indexing was a means of sorting and signposting the data rather than attributing meaning (Spencer et al., 2014). Due to the large amount of data to be coded, I chose to use the computer assisted software package NVivo to undertake the primary, low level coding. I am familiar with the criticisms regarding the validity of using software to facilitate qualitative research, in that it takes the researcher away from the data they are analysing (Sprokkereef, Larkin, Pole and Burgess, 1995, Weitzman & Miles, 1995). However, NVivo facilitated the clerical management of the data.

As I read through the transcripts of observations and interviews I attached simple nodes, such as ‘deferring to others’ and ‘staffing’ to particular acts or information (see Appendix 13). I tried hard not to infer meaning by reminding myself that it was the midwives’ voices I wanted to hear. I was aware, however, of the critical nature of my integral role and potential influence of my subjective assessments on the data (Wolcott, 2002). I found coding difficult at first, as once more I appeared to be

generalising what was happening. In an attempt to remain close to the data and avoid generalisation I employed Spradley's (1980, p.93) semantic relationships (strict inclusion, spatial, cause-effect, rationale, location-for-action, function, means-end, sequence and attribution). The strict inclusion relationship was x is a kind of y; spatial was x is a place in y etc. This helped me simply to say what was happening under these terms. An example of this can be found in Appendix 14.

Following the preliminary coding seventy-one codes had been developed, although with some overlapping subject areas and some repetitions. Taking account of any repetitions or overlap and examining the nodes again facilitated the merging of nodes into more over-arching themes. Hammersley and Atkinson (2010) suggest that understanding patterns of action can involve understanding of the informal or formal cultural rules at play.

In-depth Analysis

The codes were re-examined to determine any overarching themes that were apparent. NVivo facilitated the examination of the large amount of data and the coding of the nodes into general themes. However, it became difficult to compare and contrast different nodes and any repetitions and therefore the content of the nodes was printed out to enable me to do this. The nodes were read and re-read and eventually nine categories emerged (see Appendix 15) that were represented in the two overarching themes, 'safety' and 'identity' (see Appendix 16). Sharing the data with my supervisors and discussing issues also facilitated the generation of the themes.

Analysing Critical Ethnography

Thomas (1993) suggests that critical ethnographic data should be organised in ways that explore repressive meanings in a scientific way. Thomas (1993) also suggests science is a way of thinking not just a technique for data processing. Critical

ethnographic analysis aims to decode the manner in which acts of culture create unequal power relationships (Carsprecken, 1996) and that the types of power consented to, are a feature of the culture. However, I also searched for things that positively affected the power balance to enhance a more salutogenic and balanced approach. Concentrating upon 'pathogenesis' and negativity, (although I recognise power is not always used negatively) may, as Antonovsky (1996, p 14) suggests, have a 'moral face'. Although discussing health promotion, Antonovsky (1996) suggests that when working within a pathogenic orientation (for which critical ethnography has been criticised), one is pushed in this direction and may be pressured to forget the complexity. Downe (2009 p 289) also suggests that having a salutogenic approach makes processes work well and may hold the answer to making positive change in many areas including maternity care.

However, it is not clear in the research literature what technique could or should be employed to analyse critical ethnography. To support critical analysis in her research, Dykes (2005) undertook a final reading, recommended by Thomas (1993), to identify issues relating to ideology, power and control. Hughes et al. (2002) employ a thematic content analysis approach. Carsprecken (1996) suggests that the critical ethnographer identifies ways in which alternative interpretations of cultural acts or symbols can be displayed. Carsprecken (1996) adapts Weber's Typology of power (1978) to search for forms of interactive power, such as rational or legal, contracted/coercive, traditional normative and charismatic. It was quite late in the analytical process, whilst examining the central themes of 'safety' and 'identity', that I recognised similarities in the data with Bourdieu's Theory of Practice (Bourdieu 2013), such as the inter-relationship of the labour ward environment, the behaviours of the identified clinical leaders and the power relations that appeared to exist.

Bourdieu's Theory of Practice

Bourdieu's Theory of Practice seeks to understand and interpret the actions of individuals or groups of people. The theory is relational in that it suggests the properties of people and things are only distinguished by their relationship with other properties (Bourdieu 1997). Bourdieu suggests that 'truth is not an absolute expression of things in themselves, as much as a set of relations which are partly determined by the conditions of their realisation' (Grenfell, 2012, p. 23). The structure of a field, a person's position in it and the historical path a person takes to arrive at the place establishes the person's ability to use the resources that are available locally to develop legitimate characteristics, relationships and behaviours (Bourdieu, 1997).

The analysis of power is central to Bourdieu's sociology. He elaborates on Max Weber's forms of power, suggesting more subtle and widespread forms of capital exist and are spread unequally across social groups (Swartz, 2013). I use the term capital as Bourdieu suggests, to distinguish it as a power resource: capital confers the ability to be powerful. Bourdieu (1997) attempts to discover how hierarchical social systems and domination continue to be legitimated and replicated in subsequent generations with little resistance from or awareness of the people within the systems. He suggests that power relations can be misrecognised as something other than power relations (Bourdieu, 1997). Those who are dominated may assume that their domination is natural and acceptable: they may misrecognise the social inequalities at play and fail to oppose or resist them. Bourdieu also suggests that the manner in which social groups act cannot only be considered to be the mix of individual behaviours but are acts influenced by societal traditions, culture and objective structures within society (Jenkins, 1992), such as the places in which care takes place in the NHS and the manner in which work is organised.

Bourdieu's Theory of Practice sits well with a critical methodology as he perceived his approach as a means of liberating individuals from the pressures in the social world that dominated them (Robbins, 2012). However, Bourdieu has been criticised for being deterministic and pessimistic by concentrating upon the aspects of the environment that reproduce it (and therefore how social stability is maintained) rather than on change (Skeggs, 2004, Robbins, 2012, Swartz, 2013, Elliott, 2014). On the other hand, Swartz (2013) suggests that sociological research that uncovers legitimated power relations may lay them open to social change. Skeggs (2004) suggests that Bourdieu's work reminds us that to be dominated means change may be difficult to achieve, regardless of the resistance employed. However, pessimism, as Gramsci suggests, may also facilitate change as it requires that we take note of inequalities that exist with the belief that they do not have to continue and cannot improve unless we intervene (Showstack Sassoon, 2004). Bourdieu's work has been criticised for its complexity and rigidity and that in the past appears to have been difficult to translate. However, Calhoun, LiPuma and Postone et al. in 1993 suggested that there have, and now continue to be, sufficient translations of the work to facilitate an effective interpretation of it.

Bourdieu employed field, capital and habitus as concepts in his Theory of Practice to interpret the social world and to explore how structure, power and agency interact (Rhynas, 2005). Capital and the field form the structure, and a person's practice or agency is regulated by their habitus. A debate exists as to the primacy of agency or structure in shaping human behaviour. The debate raises questions regarding the association between human activity and its social context (Reed, 1997): whether a person acts autonomously or her/his behaviour is socialised by the structure they inhabit. Reed (1997) suggests that:

‘Critical realism provides a general conceptual framework in which the interplay between them [agency and structure], and its implications for the reproduction and transformation of organisations as inter-related networks of ‘positions-practices’ occupied and engaged in by individuals and groups can be adequately recognized and explained.’

(Reed, 1997, p.32)

The Interaction of Habitus, Capital and Field

Bourdieu (1984, p.101) represented the link between habitus, capital and field as an equation:

‘(habitus) (capital) + field = practice’

(Bourdieu, 1984, p.101)

It is the relationship between habitus, capital and the field that offers a key for understanding practice. Elliott (2014, p.167) suggests that Bourdieu’s theory is a means of ‘rethinking the relationship between identity and social structure in social theory’. The reconceptualization of research objects as field and habitus facilitates the examination of the objective structure of relationships between the positions held by people in a particular site, who strive for legitimate types of authority. It may also facilitate the analysis of the characteristics a person acquires through assuming a particular type of social and economic condition.

The equation was employed in this study as representing:

‘(characteristics of the clinical leader/habitus) (their power/capital) + labour ward
(the field) = clinical leadership practice’

Rhynas (2005) states that:

‘Habitus interacts directly with capital as individual actors work in pursuit of capital but are internally regulated by their habitus. However, the influence of the field is crucial, as the action is both constrained and given meaning by the context in which it takes place.’

(Rhynas, 2005, p.182)

Elliott (2014, p.166) suggests that habitus and capital are related in that habitus may be socialised and exhibited as 'cultural taste and social preferences' that are also 'expressions of power and social class'. The manner in which we distinguish ourselves may therefore be hierarchical; and as Lawler (2004, p.113) suggests 'not all habitus are worth the same'. Bourdieu (1992) suggests that both habitus and the field influence the other: that habitus develops over time and that people are not just the bearers of structures (May & Powell, 2008). Habitus and the field may be one and the same thing: the field structures the habitus and the habitus is influential in determining the field as somewhere 'worth investing one's practice' (Grenfell, 2007, p.59). The field is therefore a human construct and also constitutes social action by creating dispositions in people to think and practice in a particular manner. The field is a means of socialisation. Bourdieu also suggests that habitus, capital and the field are of equal importance in his equation (Grenfell, 2007).

Rhynas (2005) suggests that by applying Bourdieu's theory to the practice of nursing (and I would also suggest midwifery), the agency of nurses (or midwives) may be determined through the exploration of the interaction of habitus with the structure of the field and capital. Recognition of the capital afforded to people within organisations appears to be central to a critical ontology and explanatory framework, as capital may affect a persons' agency, in that they may be able to employ this or be denied it in their interactions with others.

Capital

'Capital represents the power of a person and can be exchanged or used in order to improve their position within the field.'

(Rhynas, 2005, p.181)

Bourdieu suggests that both understated and persuasive forms of power exist in institutions and social life, through cultural resources, such as knowledge and education and symbolic categories, such as class and position (Swartz, 2013). He

alludes to several forms of capital that exist (see Table 4). Capital can be created, consumed, accumulated and exchanged, and that it is unevenly distributed within social life (Moore, 2012, Swartz, 2013). Moore (2012) suggests that although Bourdieu acknowledged the importance of economic capital, in that it may confer power and privilege, he did not intend capital in his theory to be understood in Marxist terms. He conceived that symbolic and cultural capital, such as position or knowledge, is also important, as the exchange of these types of capital may be central to the development and reorganisation of the field when influence is re-assigned and groups attempt to enhance their capital (Moore, 2012).

Table 4: Bourdieu's Forms of Capital and Power (Adapted from Swartz, 2013, Moore, 2012)

Capital	Subtype	
Social		The value of networks and social contact with individuals or groups.
	Political	Capacity to mobilise support for a candidate or leader. Can be; Professional: specialised knowledge Delegated: authority granted to position- occurs in hierarchies and political organisations.
Cultural	Embodied	Embodied cultural capital can be derived through knowledge or physical demeanour, such as teaching, valuing others and being motivational.
	Objectified	Relationship with material objects- art/books/machines
	Institutionalised	In particular institutions, such as hospitals or schools
Economic		Profit from money or trade.
	Economy of practices	Profit can be found in practices. A range of functions and ends.
Symbolic		A form that capitals take when their worth is recognised by others.
Symbolic Power		Unquestioned, arbitrary power, justified by others. Leads to domination. Naturalised – accepted May be misrecognised as arbitrary.
Symbolic Violence		Occurs when arbitrary conditions are misrecognised. Accepted even if disadvantaged. Contributes to subordination and domination.

Capital is a resource that confers the ability to be powerful: it is the force that drives the development in the field and is employed in the struggle for the control of social structures (Moore, 2012). The value of capital depends to some extent on it being

recognised socially and for resources to become capital they have to become the 'instruments' of struggle within the field (Swartz, 2013, p.56). Capital becomes symbolic when it is recognised by others as having worth and is embodied in positions in hierarchies, such as professions. Symbolic capital confers symbolic power which may be arbitrary, legitimised by others, leads to social order and rules being unchallenged and therefore maintains hierarchies.

Symbolic violence is a term that Bourdieu employed to capture an impact of symbolic power. Swartz (2013) suggests that Bourdieu perceived symbolic violence to be:

'Misrecognised obedience: that symbolic power is accepted as legitimate rather than as an arbitrary imposition.'

(Swartz, 2013, p.83)

One of the objectives of Bourdieu's theory is to determine whether symbolic violence is at play or whether people are aware of the nature of symbolic power and seek to accept it. The data were re-read for all forms of capital and power.

The Field

'The field provides the frame of analysis for the study of any aspect of social life. It can be described as a series of structures, institutions, authorities and activities, all of which relate to the people acting within the field. It is not a static entity, but changes as practices or power dynamics challenge the boundaries of the field.'

(Rhynas, 2005, p.181)

Bourdieu suggests that the field should be the main area of study in research studies, as the relationships within it are perceived to be more important than the individuals (Rhynas, 2005). To understand exchanges between people it may be insufficient to examine only what occurs. In order to understand interactions it is necessary to examine the 'social space' in which they happen (Bourdieu 1989 p.14). Bourdieu compared a social field to a football field as the social field:

‘Consisted of positions occupied by agents (people or institutions) and what happened on/in the field is consequently boundaried. There are thus limits to what can be done, and what can be done is shaped by the conditions of the field.’

(Thomson 2013, p.66)

The field is a structured space and power arena where a struggle for the distribution of valued resources (capitals) and over what can be defined as valuable exists (Swartz, 2013). The field is therefore the means of the production of symbolic capital and its character may be delineated by the manner in which the capital within it is configured (Grenfell, 2007). The struggle in the field occurs between those in dominant positions who hold more capital and those in a subordinate position with less.

The fields of power in this study were the labour wards at Springdale and Northvalley. I have already suggested in chapter two (p.46) that the labour ward is a place where contentious gendered, hierarchical relationships and ideological tensions exist and therefore employing Bourdieu’s Theory of Practice may facilitate an understanding of how this may impact on the practice of clinical leadership. The field/labour ward may be important as organisational structures and the environment may influence the behaviour of those within it. However, it is acknowledged that society as a whole and others who engage with the field may also influence and shape it. Rhynas (2005) suggests that the characteristics and future development of the field may have the potential to be changed by the structures, relationships and interactions between the individuals within it.

Habitus

‘Habitus’ is defined by Bourdieu as something that related to people (whether individuals, groups or institutions) that was structured (open to objectification: what we are) and a structuring structure (generates thought and action: who we are) (Greener 2002). Our behaviour and who we are is therefore affected by many things, such as culture, tradition, religion, history or perhaps where one practises. Bourdieu

used the term to facilitate an understanding of some of the aspects of life that cannot be understood by only examining people's collective actions. Bourdieu perceived habitus to be a dualism of the individual and the social (Maton, 2012). Habitus may be developed by learning iteratively to act by imitating others, unconsciously adopting their behaviour (Lane, 2000) and may be accepted behaviour that is not called into question. A person's habitus may therefore be socialised, which Jenkins (1992) suggests is important as it distinguishes it from that which is formally taught.

Rhynas (2005) suggests that habitus may influence how nurses/midwives perceive the needs of and deliver care to their clients and therefore is an important consideration as it may determine their practice. The professional habitus and well established dispositions attributed to midwives may have a bearing on how they operate. Bourdieu suggests that social fields have their 'own distinctive logic of practice' that guide the behaviour within the field (Thomson, 2013 p.68). A person's habitus therefore only makes sense in context and the context they inhabit equips them with the 'rules of the game' or 'doxa': the knowledge of the legitimate practices in the field that support those practices (Bourdieu, 2013, p.198 and p.159). Should the 'doxa' be accepted without question they may be all the more powerful (Swartz, 2013). Elliott (2014) suggests people acquire a feel for the game over time which they use as a basis for discerning their action in particular situations. Mastery is achieved through experience and a tacit understanding of the rules. The habitus of the clinical leaders was considered by examining their perceived characteristics, behaviours and relationships with others within the field in an attempt to derive meaning.

Summary

A topic centred critical ethnography was employed to critically explore clinical leadership on the labour ward. A critical methodology is derived from a belief that

power exists in all types of social action. A critical ethnography appeared to be the most appropriate methodology to critically explore the interpretation of clinical leadership and how it was enacted in relation to the inequalities in power that may exist on the labour ward. Whilst critical, positive aspects of clinical leadership were also examined in an attempt, to counteract the potential for negativity and harm to the midwives. A critical approach suggests research for change. The intention is that through the dissemination of the findings and recommendations of the thesis changes in practice may occur.

A reflexive approach to critical ethnography, being aware of the potential impact of my beliefs on the findings and striving for an honest and critical appraisal of the data contributed to the authenticity of the research findings. My own experience as a midwife on the labour ward facilitated some understanding of the midwives experiences. However, recognising that the midwives' experience was unique to themselves and taking a critical approach, wearing shoes that did not quite fit facilitated a 'theorised subjectivity' and prevented a taking for granted approach. Tension existed between maintaining a balance as a researcher and a midwife and insider and outsider. Revealing my own discomfort and concerns, being honest and transparent was important to produce a balanced view. Relational skills were required, such as sensitivity and rapport to develop a participatory approach and at the same time to recognise my position as a researcher.

Negotiating access to Northvalley and Springdale involved facilitating relationships with the gatekeepers and the midwives who appeared to view the research with suspicion and who required some reassurance and to be accorded respect. Being aware of the power relationship between myself and the midwives and taking steps to equalise any differences was a means of preventing the distortion of truth that may occur if relationships are hierarchical. The use of the ranking system was useful to facilitate the writing of the findings and to provide anonymity for the midwives.

However, ranking inferred regimentation and hierarchy. The use of pseudonyms, however, personalised the midwives and an acknowledgement of my discomfort of using the powerful terms may have mitigated their use.

The appropriate ethical approval for the research was given and the midwives involved were fully consented to take part and aware of what would happen to the data. Informed consent was facilitated through the provision of information and consent sheets and verbal information. The data was securely stored in line with the BSA (2002) standards. Data collection commenced in March 2013, continued over a nine month period and ended in October 2013.

A purposive sample of forty-eight midwives represented the diversity of the midwives in two labour wards in two NHS trusts in the North of England and facilitated an ability to make representational generalisations. Thirty preliminary semi-structured interviews critically explored the characteristics of clinical leadership and power relationships on labour ward. Semi-structuring the interviews facilitated meeting the aim and objectives of the thesis, whilst remaining conversational with opportunities for the midwives to contribute to what was discussed. The midwives who were interviewed were asked to nominate who they perceived to be 'effective' clinical leaders that appeared to assuage the negativity associated with a critical approach. The midwives nominated were subsequently interviewed (n=18) to determine their experience of being a clinical leader.

Approximately sixty-nine hours of non-participant observation (see Appendix 7) was undertaken in total. Non-participant observation was chosen to minimise the effect that I had on the midwives' behaviour, although attempting to be unobtrusive was often difficult. Non-participant observation facilitated my ability to meet the aim and objectives of the thesis. A flexible observation schedule enabled the capture of a wide range of activity on the labour wards. Two hourly observations facilitated the accuracy

of the subsequent recording and therefore the credibility of the data, as did the digital recording of all the interviews. A mixture of interviews and observation were undertaken to identify potential cover ups or confirm what had been seen or heard.

Analysis of the data commenced during observation and interviews and drove the research. I then became immersed in the data through the transcribing, reading and re-reading of the data. The use of NVivo facilitated the management of a large amount of data and the preliminary indexing and coding. Ten themes were developed that were incorporated into two overarching themes of 'safety' and 'identity'. The means of analysing critical ethnographic data is unclear in the research literature. However, Bourdieu's Theory of Practice, that suggests clinical practice may be rationalised by exploring a combination of a person/group's habitus and capital and the field within which they practice, appeared to be an appropriate analytical tool to apply. I therefore examined the data through the lens of Bourdieu's Theory of Practice as a means of critically exploring clinical leadership through the interrelationship of the clinical leaders, labour ward and the power relationships that existed.

The following three chapters will critically discuss the two main themes of the findings, 'safety' and 'identity' through the lens of Bourdieu's Theory of Practice to highlight who the clinical leaders were perceived to be, the power relationships that existed and to critically explore clinical leadership practice and its impact.

Findings and Discussion: Chapters Five, Six and Seven

CHAPTER FIVE: CLINICAL LEADER HABITUS AND CAPITAL IN THE FIELD

Introduction

Drawing on the findings from the fieldwork at the labour wards of Springdale and Northvalley, the following three chapters will employ Bourdieu's (1984) Theory of Practice to provide a framework to discuss the overarching themes of 'safety' and 'identity' that emerged from the data (see Appendix 16). The findings from both Springdale and Northvalley are examined as a whole due to the similarity of the findings at both sites. However, differences are acknowledged, highlighted and rationalised as they appear. I will discuss how the clinical leaders' practice evolved through their habitus, capital and relationship to the field to become that of guardianship to enhance the safety and identity of themselves and other midwives in what appeared to be an 'unsafe' field. Bourdieu's theory is employed as a framework to demonstrate the changes in the clinical leaders' habitus that were developed in the field and the capital required to facilitate this guardianship. This first chapter will explore the habitus and capital of those perceived to be clinical leaders on labour ward.

Labour Ward Coordinators as Clinical Leaders

The views of all the midwives at both Springdale and Northvalley suggest that the clinical leaders on labour ward were the Band 7 Labour Ward Coordinators (LWCs). The habitus of the LWC was what other midwives attributed to clinical leadership. The midwives described the LWCs as being '*beacons of leadership*' (Donna B72N), '*managing and coordinating*' the activities during each shift: being '*in charge*' (Marilyn B61); '*leading the shift*' (Eve B62); '*having the most experience*' (Selma B51) and '*taking most of the heat*' (Donna B72N), in that they controlled the activity on labour

ward, were held responsible for the care women received and advised and supported midwives.

I see clinical leadership as Band 7 Co-ordinators. To me they are the clinical leaders on labour ward who sort of participate in the care provided to the women.

(Laura B62N)

Many of the midwives that were interviewed perceived having someone in charge to coordinate the work was necessary and the norm, as Marion (B51) stated:

I don't think a labour ward would run without clinical leaders. There has to be someone in charge that hands the workload out... that you can go to that, you know, it's like with any job, there is always someone you go to or someone in charge who dictates really.

(Marion B51)

Although Marion suggested that the midwife in charge dictated, Harriett (B52) stated that the clinical leader on labour did not tell others what to do but rather the midwives '*followed the clinical leader's guidance and leadership*'. The midwives on both labour wards appeared to be socialised as followers of the leader. The midwives followership was apparent in their response to the LWC. At both Northvalley and Springdale the midwives accepted the LWCs' decision with regard to the women they were allocated to care for, although the LWCs appeared to consider the midwives reactions to this:

She [the LWC] gave them [midwives] the details of the women in each room and then asked the midwives in turn, "Will you?" "Is it alright?" that they cared for a particular woman. The midwives nodded in turn.

(Fieldnotes Northvalley, 04.06.13)

However, not all of the midwives followed the LWCs clinical leadership submissively.

The resistance that existed and follower habitus will be discussed in chapter seven.

The LWCs clinical leadership habitus appeared to possess symbolic cultural capital through the perceptions that their clinical leadership was an essential and an accepted part of labour ward practice. The position of the LWC within the labour ward

appeared to be part of the doxa and the way things were done and therefore was attributed symbolic capital. The LWCs' symbolic capital was apparent as they did not use force to facilitate the compliance of their followers which suggests the LWCs may be all the more influential. Bourdieu (1989) suggests that those who are recognised by the group receive their power from the group through a lengthy process of institutionalisation. The symbolic capital the LWCs possessed gave them the power to delegate work and mobilise the group through the coordination of labour ward activity. The symbolic capital of the LWC was demonstrated whilst observing. I asked a midwife who was 'acting' as a Band 7 Midwife:

She said that the "position of the coordinator is respected in the unit... you can hear it on the phone when they know you are a Band 7 – they (the other midwives) listen. If I said the same as a Band 6 Midwife they wouldn't listen"
(Fieldnotes Springdale, 09.03.13)

Bourdieu (1989, p.21) suggests that 'titles of nobility', such as qualifications or professional positions represent symbolic property that infer legitimacy and recognition on the holder of the title. The capital inherent in the LWC position may have ensured the compliance of their followers which concurs with the clinical leadership literature that suggests some degree of power may be necessary for clinical leaders to function effectively. Powerlessness may constrain the clinical leader's potential to facilitate practice or change (Tourish, 2013). However, as we shall see in chapter seven, the clinical leader's symbolic power may also lead to a resistance to change.

The authority granted to the title of LWC on the labour ward also gave the LWCs political capital and was 'symbolic property' that gave them the 'right to share in the profits of recognition' (Bourdieu, 1989, p.21). Swartz (2013, p.60) suggests that those who are perceived to have the qualities of leaders are the objectification of political power, in that they represent a capacity to mobilise support and require the trust of others ('collective trust') and personal characteristics that instil such trust

(‘reputational capital’). The political power attributed to the LWCs position was delegated by the institution they practiced in and was also professional⁶, as we will see in chapter six.

Habitus, as I have previously suggested (p.129) is socially constructed and comprises social distinctions, which imply not all habitus are of equal worth. The differences amongst habitus may also be perceived as inequalities in the field (Elliott, 2014). The association and acceptance of the Band 7 LWC position with clinical leadership suggests they were more highly valued midwives on labour ward and that a status hierarchy existed. Status hierarchies occur when certain people within an institution or group are considered to be more important than others: in that they are accorded symbolic power and privilege. Symbolic power functions to reproduce the ‘stratified order’ in institutions (Swartz, 2013, p.98). Symbolic capital is made more powerful through its acceptance by others.

Scott (1982) suggests that the development of a hierarchy is an important mechanism for enhancing the communication and decision-making potential in systems, as well as directing and coordinating the flow of work. The status hierarchy at both Springdale and Northvalley appeared to be functionalist in nature, in that it was perceived as a necessary mechanism that was developed to facilitate the midwives’ ability to practice in a potentially ‘unsafe’ labour ward environment. Functionalistic status hierarchies may form a structure through which groups develop effective decision-making skills to facilitate the group to change and more successfully survive (Ridgeway and Walker, 2001). However, they may also perpetuate the status quo and led to insularity. The impact of the ‘unsafe’ labour ward and the agency and capital it conferred on the clinical leader will be discussed in chapter six.

⁶ Political power may have a professional form and is found in the specialised knowledge that is acquired through public service.

Although Gemmill and Oakley (1992), whom I referred to in chapter two (p.29) suggest that the requirement for a leader is a social myth that is used to control and discipline others, it appeared that the control and discipline of the clinical leaders at Northvalley and Springdale was welcomed on the whole. Ridgeway and Walker (2001, p.298) suggest:

‘In all known societies people exhibit a regular pattern of differentiations on the basis of status and the development of status hierarchies is a feature of human interaction. It is a fundamental aspect of the organisation of social behaviour.’

All of the LWCs at both Northvalley and Springdale also recognised and accepted their status and position as clinical leaders.

I do see myself as a clinical leader because of what my job is and what my role is and what my job description is.

(Judith B72N)

The LWCs appeared to recognise their clinical ability and midwifery experience and suggested that their practice had been consciously developed over the years as they ‘*would not expect to ask anyone else [another midwife] to do anything I couldn’t do myself*’ (Judith B72N). The LWCs appeared to share the same values as the midwives with regard to their position and cultural capital and therefore the LWC status appeared to be a cultural symbol of worthiness and of institutionalised symbolic power.

Duty, Capital and ‘Where the Buck Stops’

When something goes wrong the first question that is asked is; “Which Band 7 [LWC] was on?” It’s not, “Who was the Registrar [obstetrician] and who was the Named Consultant [senior obstetrician] who was covering the shift that night?” It’s always, “Who was the Band 7?” [LWC] and “Where was the Band 7 while that was going on?”

(Valerie B71N)

Although the LWCs were invested with symbolic power and hence the ability to facilitate care with little resistance, their power was associated with enhanced responsibility. The LWCs appeared to be accountable for the actions of other

midwives and the medical staff. Although the LWCs were situated in the middle of the hierarchy, they appeared to be most accountable. Mander (2004 p.136) suggests that accountability may be a ploy or a pawn 'in the power politics of healthcare and that the more powerful an occupational group is the more others are accountable to them': accountability is not always associated with those who hold the most capital. The responsibility of the LWCs resonates with the discourse of blame in the NHS and with Warwick's (2011) view, referred to earlier, that professional clinicians who take up clinical leadership positions may alone take the blame if it fails. The LWCs' responsibility appeared to place them in a vulnerable position and their accountability, as we shall see in chapter six, appeared to impact upon their control of the field.

Whilst the LWC appeared to be vulnerable, their responsibility gave them courage that may be construed as professional or personal power. Being accountable for labour ward practice appeared to facilitate the LWCs' ability to challenge and influence decision-making. Donna (B72N) suggested:

I suppose it's not being afraid to challenge where you disagree and be confident to sometimes. You do sometimes have to over-ride decisions. It always comes down to who was in charge when incidents occur. Ultimately the buck stops with me.

(Donna B72N)

The LWCs on both labour wards were sometimes required to challenge both midwives and obstetricians with regard to the decisions they made regarding their care and demonstrate their courage. Hayley (B61) described a situation when Nicola (B71N), one of the LWCs who was nominated as an 'effective' clinical leader at Springdale, disagreed with the obstetric registrar who was on the telephone to the consultant obstetrician, with regard to the proposed induction of labour for a woman who did not wish to be induced:

In the end the registrar gave the phone to Nicola and said "Oh, you talk to him" [the consultant obstetrician] (laughs) and Nicola says to the consultant, "No [we will not induce the woman], sorry, no. No. No. No and that was the end of it...and I was like yeah...go for it! (laughs)

(Hayley B61)

The LWCs' clinical leadership was also driven by a sense of duty and the responsibility that appeared to be implicit in labour ward coordination. This sense of duty required them to employ their discretionary power but also required, assertiveness, an ability to challenge, negotiate, point out mistakes, to be firm, calm and decisive. Although Judith (B72N) was fatigued she was compelled, as Gina (B72N) was, to '*communicate her feelings*':

Some days I come on and I think, unless it's life or death I am not going to interfere and I am not going to try and persuade them (the doctors) what I think but then...I keep saying to myself that it's not worth the hassle but then I feel like it's my duty and I feel that I am the advocate for the woman so really it is important that I do challenge them (the doctors).

(Judith B72N)

The LWCs' assertiveness appeared to be bound up with courage, having a sense of duty, integrity and responsibility to the women in their care and their professional values. Practising clinical leadership in accordance with their professional values appears to resonate with Stanley's (2008) Congruent Leadership Theory that defines leadership as a congruence between the leaders' actions, values and beliefs. It may be one of the reasons why some of the LWCs were nominated as 'effective' clinical leaders and suggests vocation. It could therefore be suggested that vocation may be a requirement of the LWC clinical leader if others are to perceive her/him as such. However, Gina (B72N) stated that speaking up was sometimes misconstrued as being '*difficult*' and '*argumentative*' which echoes the difficulties women may encounter with regard to the socialised view of femininity anticipated from their gender, such as compliance and deference. Women may be perceived as 'bolshy' should they disagree or refuse to comply with gendered norms. It also suggested that compliance and deference was expected within labour ward and that the obstetricians possessed more symbolic cultural capital than midwives. Gina (B72N) and Judith's (B72N) behaviour also appeared to locate the reputation of the LWCs as strong women which will be explored in the following chapter.

Possessing the ability to influence decisions may have been employed by the LWCs to protect themselves from liability and appeared to be implicated. Earlier in the thesis it was suggested that midwives practising on labour were oppressed (and therefore, to an extent powerless) by the medical model of care (Kirkham, 1999, Mcnamara et al., 2011, Martin & Waring, 2012). However the LWCs at Springdale and Northvalley appeared to hold a great deal of discretionary power as they practised in complex situations that may have required the use of intuition⁷, initiative and practical knowledge, such as facilitating an unanticipated complication in a birth, rather than referring to a manual. Scott (1982) suggests that in autonomous professional organisations, where clinicians are accountable for the care they provide, those clinicians with the most discretion may hold the most responsibility. It may not be considered that those clinicians in the middle of the hierarchy would possess the most discretion. However, Flint (1988, p.25) suggests that:

‘The most basic power the midwife has is that she does the work and can suggest particular practices are unjustified and rationalise as so.’
(Flint 1988, p.25)

The LWCs held cultural capital and power through her position and knowledge within the field. The LWCs position is similar to that of the street level bureaucrats in the work of Lipsky (1980) who interacted with the public in a bureaucratic organisation and possessed substantial discretion through their work in the field. The discretionary power imbued in those who practice at the frontline of the NHS suggests that a ‘disconnected hierarchy’ exists. Rather than those at the top of the hierarchy possessing the most power, a disconnected hierarchy suggests a power structure that is inverted: where people at the bottom of the structure have more influence over daily decision making than the people purported to be in control at the top (Edmonstone, 2009a p.293). However Flint (1988) suggests that in order for

⁷ Knowledge built upon previous experience.

midwives to use their discretionary power they may require courage (which they appeared to possess) and access to support or influence outside of labour ward. As will be seen later in the chapter the LWCs appeared to have little access to support.

Dispersed Clinical Leadership Habitus

The LWC was the person whom all the midwives associated with clinical leadership, at both Northvalley and Springdale. However, a few midwives, as well as perceiving the LWCs to be clinical leaders, also associated clinical leadership with other midwives and the obstetricians on the labour ward. The different perceptions concur with the literature that suggests clinical leadership may be interpreted and defined in different ways (Bousefield, 1997, Connelly et al., 2003, RCN, 2004, Gould, 2008, Stanley, 2008, Burns, 2009a, Stanley & Sherratt, 2010, Roberts et al., 2011 and Elliott et al., 2012). Diverse interpretations of clinical leadership may be related to clinical leadership, as a concept, remaining largely unrecognized and under-valued.

I suggested in chapter three that clinical leadership appeared to be a relatively recent term. The newness of the term clinical leadership was borne out by being unfamiliar to many of the midwives I spoke with at Springdale and Northvalley who had to *'think about it'* (Wendy B62), or found it *'difficult'* (Beverley B72) to define, and that a variety of clinicians were perceived to be clinical leaders. A couple of midwives also perceived themselves to be clinical leaders as they, *'led the direct care of the women that they cared for with support from others'* (Frances B62). Frances' (B62) statement reflects the principles of autonomy espoused by their professional body, the Nursing and Midwifery Council (NMC, 2012) and suggest some midwives perceive they had some control over their decision making and therefore some cultural capital was attached to their habitus as midwives. However, as I will discuss in chapter seven the autonomy of the midwives practising on both labour wards appeared to be tenuous.

Obstetricians as Clinical Leaders

Clinical leadership habitus, was also attributed by a few of the midwives to the Obstetrician. The Obstetricians were perceived to be clinical leaders through their habitus and political and cultural capital within the field. The obstetricians' political and cultural capital appeared to be related to a responsibility for high risk pregnant women and their social status and place at the top of the hierarchy. Two of the midwives at Northvalley stated that obstetricians '*made decisions with regard to women's care*' (Carmen B62): that they were '*the patient's clinical lead*' (Christina B62). Their views related to the obstetricians' remit to be responsible for women at high risk of complications and may have been compounded by the majority of women being high risk on the labour ward at Northvalley since the opening of the Birth Centre. The obstetricians' responsibility for high risk women conferred them legitimacy and symbolic power in the field, as the necessity of their position in the field did for the LWC. By legitimacy I suggest that the obstetrician's responsibility rationalised and gave value and subsequent power to their position. Jenkins (2007) suggests that being perceived as legitimate gives credence to particular practices or people that may then become arbitrary and systematic but conceal the power relations that may be involved in the legitimisation. However, Vinzant and Crothers (1998) suggest that public servant leaders, at the front line of care, work in contexts that necessitate that their practice is legitimated rather than being assumed, due to the associated accountability. Legitimacy, agency and symbolic power may also be important to the clinical leader in relation to the discretion that may be required when making decisions in a complex and changing environment.

Those midwives at Springdale who suggested the obstetricians were clinical leaders perceived that the consultant obstetricians were above midwives in the hierarchy. Leslie (B81), the matron appeared to have a sense of her place and that of the obstetricians when she stated:

We all know a consultant's, a consultant and a midwife's just a midwife.
(Leslie B81)

Bourdieu (1989, p.19) suggests that 'nothing classifies somebody more than the way he or she classifies themselves' and the dominated tend to adopt a dominated view of themselves (Swartz, 2013). Irene (B71) suggested that class and gender issues featured in the hierarchy at Springdale when she spoke to me about her encounter with one of the obstetric consultants. She described behaving in a subjugated, female, deferential manner where she felt able to touch the obstetrician:

...we have different relationships to them [the consultant obstetricians]. So, the one that's on today...he's quite laid back. You can talk to him and use his first name, you know, have a laugh with him and I even touched him today on the arm and said "Come on now go in that room", you know, like I would ... not to my Dad but, you know, normal. But the one [consultant obstetrician] that were on yesterday I would never. I would call him Mr whatever his name is, you know, I would never call him by his first name because he has a different air about him.

(Irene B71)

The manner in which Irene related to the consultant obstetrician appeared to infer that some social status was accorded to him that enhanced his cultural capital in the field. The cultural capital embodied in the medical profession through their social status was also apparent by the vicarious respect that Valerie (B71N), one of the LWCs at Springdale received, whose husband was a general practitioner (GP). Several of the midwives and one of the health care assistants suggested that I should speak to Valerie as she was perceived to be '*perfect*' and '*wonderful*', as well as being a '*General practitioner's wife*' (Fieldnotes Springdale, 01.03.13).

It's like being a bit 'up there' for us. I think that does like give her some kind of standing, you know, cos she's a doctor's wife.

(Irene B71)

Having a midwife in their group with enhanced cultural capital may have elevated the group's own status. However, whilst Valerie appeared to derive some cultural capital through her husband's professional status she also appeared to demonstrate the

qualities, such as valuing and motivating people that appeared to delineate the 'effective' LWC clinical leaders from the others.

The deference accorded to the Consultant Obstetrician's position in the hierarchy on the ward round at Northvalley may be conceived as being similar to that at Springdale. I observed:

The LWC lead what appeared to be a 'procession' of approximately six or seven junior and senior obstetricians and anaesthetists around the labour ward to see the women. The LWC stopped outside each room and gave a resume of the woman's progress and the consultant obstetrician entered the room followed by the LWC and the other doctors and was the first to leave whilst the junior obstetrician remained in the room to write in the woman's notes with regard to the outcome of the consultation. This process occurred at each woman's room and appeared to be reminiscent of the 'Doctor at Large' films of the 1960s that portrayed a stereotypical central and powerful role of the senior consultant (doctor).

(Fieldnotes Northvalley, 12.04.13)

Although the midwives at Northvalley did not articulate the difference in their social status with the obstetricians, their involvement in the routines, such as the ward round appeared to demonstrate it.

Habitus is thought to be deeply social and traces of distinction, such as class, race, gender and sexualisation are all marks of habitus (Lawler, 2004). Class, race and gender are all associated with inequalities of power. Bourdieu suggested that habitus is socially produced (Bourdieu, 1989) and the midwives apparent deference to the obstetrician's social status as men (although some are women) and as professionals may be a mark of their habitus that had been developed over time and outside of their work as midwives. In a capitalist society, the association of medicine with enhanced remuneration may also impact on the perceptions. However, it appeared that not all habitus were the same or equal and appeared hierarchical in that it may not have mattered what you do, but who you were in the hierarchy. McDowell and Pringle (1992, p.160) suggest that:

'While organisations might appear to be sexless and gender neutral, sexuality and gender are actually central to the constitution of workplace power relations.'

(McDowell & Pringle, 1992, p.160)

The deference of the midwives suggests that organisations, such as the NHS are not only hierarchical but social in nature. Cohen and Prusack (2001) suggest that being associated with more mechanistic and systems oriented activity may mask its deeply social nature (Cohen & Prusak, 2001).

McDowell and Pringle (1992) suggest that social class is usually associated with a person's occupation. The hierarchy at both Northvalley and Springdale appeared to be based on class and rank. The apparent inequalities of status capital between the midwives and obstetricians appeared arbitrary, however, they were naturalised and incorporated into daily practices, such as the ward round and therefore appeared to be misrecognised by both professions. The midwives appear therefore to take part in their own domination. Arbitrary conditions that are misrecognised and accepted, even if there is disadvantage for those who accept them, can be perceived as a form of symbolic violence. Swartz (2013, p.97) suggests symbolic violence is a kind of 'possession' where persons are predisposed to comply, due to their prior experience, with the institution as they have become as one with it. The difficulty with symbolic violence is that it may prevent those affected by it to recognise the arbitrariness of their conditions and their ability to change them.

Despite the apparent deference to the obstetricians the LWCs retained a degree of symbolic cultural power as they were recognised as clinical leaders despite the perceptions of the senior midwife at Springdale. Leslie, the Matron at Springdale, suggested that in her view clinical leadership was the remit of the consultant obstetricians and anaesthetists in conjunction with herself:

...But here [at Springdale] it's the Band 7s [LWCs] [who are the clinical leaders].

(Leslie B81)

The LWCs also appeared to hold some discretionary power over the obstetricians as Jacqueline, the Consultant Midwife at Northvalley suggested:

I think that the consultants and all the doctors, sort of the registrars and the SHOs (senior house officers) will be very much led by what the senior midwives [LWCs] feel is right.

(Jacqueline B82)

Deference to the LWCs appeared to occur through respect for their knowledge that constituted cultural capital, rather from their position in the hierarchy. Deference may also have been accorded with regard to which profession was perceived to have jurisdiction of the field as will be seen in chapter seven.

The ‘Wing Man’

A few midwives suggested that other midwives, in addition to the LWCs, were perceived to be clinical leaders. Other midwives were attributed political and cultural capital with regard to their practical knowledge and seniority in relation to other midwives. Florence (B71) suggested there were:

...different levels of leader. It depends how you're looking at it: as just the shift leader or just to work amongst each other which can be like one Band 5 working with a senior 6 ...them leading that Band 5, you know. You know you're safe because you've got somebody to be supporting them if they need it.

(Florence B71)

The Band 6 midwives, ‘being supportive’ (Adele B51) and ‘giving advice’ (Hannah B52) to less experienced midwives with regard to care decisions, in the absence of the LWC, was equated to clinical leadership. The clinical leadership literature suggests that clinical leadership is required and exists at all levels of staff in a chaotic health system within the NHS hierarchy as it may facilitate a shared understanding of the complexities of care characteristics (Burns, 2001, Stanley, 2006, Ham, 2014). This appeared to be happening to an extent at Springdale and Northvalley. However, the suggestion that Band 6 Midwives were clinical leaders on labour ward appeared

to be derived from discussions during interviews with regard to who the clinical leaders were. The Band 6 Midwives did not appear to be the first midwives that came to mind when other midwives acknowledged who they perceived the clinical leaders to be but were acknowledged as contributing to clinical leadership. However, when the midwives were asked if they were able to identify any of the Band 6 Midwives as 'effective' clinical leaders, five were nominated across both labour wards. Those who were perceived to be 'effective' clinical leaders were surprised that they had been chosen (although so were some of the LWCs who were perceived to be 'effective' clinical leaders), which appeared to resonate with Stanley's (2006) study that found paediatric nurses who were nominated as clinical leaders came from a range of grades and did not recognise themselves as such.

Midwives approached the Band 6 Midwives for support and reassurance when the Band 7 LWC was 'busy' (Marion B51) or to ask 'silly little questions' of (Selma B51) that they may be worried to ask of the LWC. The capital of the Band 6 midwives did not appear to be symbolic in that their leadership was not recognised as the norm within the hierarchy, although it was recognised amongst the junior midwives as being a valuable support. The Band 6 midwives appeared to recognise that they possessed some leadership skills, although acknowledged that their influence may have been limited to supporting other midwives:

I think leadership on here would come in all forms. You know, as a Band 6 [midwife], we're supporting the Band 5s and might be helping them with their plans of care and I would still class that as leadership erm...and it would depend if it's a ward round and you've got a consultant coming in and advising on your plan of care and then perhaps they're [the LWCs] [leading]...so it comes in all forms doesn't it?

(Eve B61)

The Band 6 Midwife was often appropriated as the 'Wing Man' to support the LWC:

... I always try and say, if I've got a Band 6 [midwife], you're my 'Wing Man' today. If anything's going off and I'm not there, come and tell me. It's nice to have one another to rely on and to run things by. That makes such a difference if you're on with a competent Band 6 [midwife]... or another Band

7. It takes so much stress off you. If you can have one [midwife] like supernumerary [coordinating activity] and one on as a clinical expert [advising and supporting other midwives] which is what we're trying to do.

(Karen B71N)

The LWCs' clinical leadership appeared to consist of both coordinating activity and providing clinical expertise. The LWCs at both Northvalley and Springdale were expected to be supernumerary, in that they were not expected to give direct care to women in order to facilitate their availability for other clinicians. However, when emergencies arose the LWCs were expected to attend and did so to support the care given:

Lots of staff were around ward clerk's desk: midwives and doctors, a consultant obstetrician, registrar and two house officers had just attended a shoulder dystocia on birth centre with the coordinator [LWC], who appeared flustered from this as she was flushed [her face was red and sweaty] and she was wiping the back of her hand over her forehead.

(Fieldnotes Northvalley, 02.07.13).

The LWCs' responsibility for coordinating the work on labour ward appeared to take them away from giving direct care. On both sites the LWCs located themselves in the office. Gina (B72N) suggested that due to the busy labour ward environment, coordinating the activities and dealing emergencies was more her responsibility whilst the involvement in giving and supporting direct care was no longer her '*bread and butter*'.

The 'Wing Man' appeared to be a position that had developed in response to the changes in the field. The 'Wing Man' was represented by either a clinically experienced Band 6 Midwife or a LWC:

The night staff was on duty and there had been one Band 7 Midwife and usually a senior Band 6 Midwife would have supported her however it had been a quiet night and this had not been necessary.

(Fieldnotes Northvalley, 14.09.13).

When two LWCs were working on the same shift, the midwife who was not designated to be 'in charge' of the labour ward became the 'Wing Man', who would act as a support. It was often the 'Wing Man' who was involved in supporting the

other midwives with practical caring issues, such as *'assistance with suturing, instrumental birth or active pushing'* (Laura B62N). This may be why the Band 6 midwives were nominated as 'effective' clinical leaders and suggests clinical leaders may also be associated with their involvement in supporting care-giving, which is closer to my own perception of what clinical leadership is and that has the potential to impact upon the giving of direct care. The development of the 'Wing Man' position suggested that the priority for the LWC appeared to be the coordination of labour ward activity, rather than facilitating direct clinical care. The LWC did not appear to have the capacity to both coordinate the ward and offer clinical advice when labour ward was busy. However having less control over direct clinical care giving and yet being accountable for whatever happened on labour ward appeared to place the LWC in a vulnerable position.

The political and cultural capital that the Band 6 Midwives, who were nominated as 'effective' clinical leaders, possessed appeared to be associated with their expertise, rather than their place in the hierarchy. Clinical credibility, as will be seen in chapter six, was deemed to be important in a busy labour ward. Clinical grade was not always associated with having the most clinical knowledge and experience, and ironically, potentially more cultural capital, as some of the Band 6 Midwives had more clinical experience than some of LWCs. Beverley, a LWC suggested:

Some of the senior Band 6s who have worked on labour ward for a long time but aren't necessarily Band 7s [LWCs] but have, you know, a lot of clinical skills and they impart a lot of knowledge really. I would go to them as my clinical lead, so... and you know some of them have been midwives for twenty or thirty years you know, haven't they? There's a lot of experience there.
(Beverley B72)

Symbolical cultural capital did not appear to be solely tied to clinical acumen but was invested in a clinician's position in the field, which suggests that clinical leadership may not be distributed amongst all midwives as they may not possess the power to facilitate their discretion (even though they possessed the necessary skills).

The exception to this was Kelly (B62N) who had been qualified for four years which suggested that the length of clinical experience was not the only pre-requisite for being viewed as a clinical leader. Kelly was practising on the birth centre at Northvalley and was nominated as an 'effective' clinical leader by one midwife. Kelly was surprised that she had been nominated, although she was practising on the birth centre as a '*shift leader*' despite having a relatively few years' experience. Kelly (B62N) perceived her ability to *support* and *advise* other midwives and being able to *coordinate* the work may have been why she had been nominated. Kelly (B62N) may have been associated with possessing some of the characteristics of the LWC in that she was '*in charge*' and had to make '*decisions for the whole team*'. These characteristics were associated, as we will see in chapter six with the embodied cultural capital that the LWCs possessed. It appeared that although the midwives on the birth centre perceived that the hierarchy was much '*flatter*' (Kimberley B72) than that on labour ward, the behaviour of the LWC appeared to have been learned and transferred to those leading each shift on the Birth Centre. The socialisation of behaviour may lead to it becoming the norm, acquiring symbolic capital and power that perpetuates ways of practising that may then be difficult to change. The socialised nature of the LWCS' clinical leadership and its implications will be explored in chapter seven.

The 'Wizard of Oz'⁸

Clinical leadership habitus was also recognised in the midwifery matron, consultant midwife and heads of midwifery (HOMs) by a few midwives, which resonates with the clinical leadership literature (Christian & Norman, 1998, Connelly et al., 2003, RCN, 2004, Redwood et al., 2006, Gould, 2008, Manley et al., 2008, RCN, 2009, Mitchell et al., 2010, Franks & Howarth, 2012). The matron, consultant midwife and HOMs

⁸ The Wizard of Oz is a character in children's fiction who was seen as a great and mighty leader who was only seen on a screen whose image was controlled by a small man behind a curtain. He was therefore heard but not really seen by others.

appeared to be considered clinical leaders due to their rank at the higher end of the midwifery hierarchy, being a 'step above' the LWCs (Amy B62). Although these senior midwives were perceived to be clinical leaders in the maternity services, they were not readily perceived as clinical leaders on labour ward. June, the Matron at Northvalley was the only senior (I refer to the matron as senior to denote the pay banding 8 on which he/she is remunerated, although as already suggested I am uneasy with regard to attributing seniority or potential worth to pay) midwife who was nominated (by one midwife), as an 'effective' clinical leader as she was perceived to be '*instrumental in affecting change*' (Frances B62) and had a more strategic view with the potential to be *influential* in practice. However as June (B82N) suggested:

Oh you can't be a clinical leader on a labour ward any more. I haven't got that ... presence. I have been a labour ward manager for many years and I had clinical credibility. I could influence it more when I was in practice because people could see me question and challenge.

(June B82N)

Jacqueline, the Consultant Midwife at Northvalley, although having a remit to facilitate normal birth, spent 'a lot of the time' (Jacqueline B82) on the birth centre rather than the labour ward. The workload of these senior midwives appeared to remove them from labour ward. Gina (B72N) suggested that the workload of the HOM and matron at Northvalley meant that she did not '*see her [HOM/matron] unless I go and see her*' which was difficult for Gina herself when the labour ward was busy. Visibility and presence in the clinical environment appeared to be an important factor in whether a midwife was considered to have symbolic cultural capital as a clinical leader on labour ward or within the maternity service. Day and Harrison (2007, p.363) suggest that leadership 'always requires some sort of interpersonal relationship' and that without that social connection a person 'cannot be a leader'. Both matrons, as those in the literature (Bousefield, 1997, RCN, 2004, Gould, 2008, Burns, 2009a, Carryer et al., 2009, Roberts et al., 2011, Elliott et al., 2012, Franks & Howarth, 2012) found it difficult to influence care and be visible in practice. Leslie (B81), the Matron at

Springdale suggested that there appeared to be an emphasis placed upon being visible and she explained that she found it difficult to be visible to everyone. To be visible to she would have to:

... Go round every member of staff and say "hello, I'm here...I am here. I'm not in my office, I am here."

(Leslie B81)

Leslie's apparent frustration appeared to highlight the difficulty of being visible and the heavy workload that she appeared to struggle with. The impact however of the lack of input from the matrons and HOMs appeared to leave the LWCs feeling unsure of the support on offer:

I think it's very easy for managers to become a bit like the Wizard of Oz. It [the manager], it's a big voice but nobody behind it. Do you know what I mean? You don't see them [managers] but then every so often something might happen or you just feel that this thing (laughs) is saying you've got to do this and no discussion. So I don't think we particularly get as much support but probably if I really needed it, it might be there.

(Sylvia B71N)

The midwifery matrons and HOMs appeared to have bureaucratic capital, in that they gave direction to the LWCs and their symbolic power related to their accepted position in the hierarchy. However, the lack of their support for the LWCs as clinical leaders appeared to have an impact on the development of the LWC clinical leader habitus. It was apparent at both Springdale and Northvalley that the ward manager position was not available as a means of support. At Springdale the ward manager was a 'new post' (Irene B71). Two midwives shared the post and were responsible for 'managerial areas' (Irene B71). At Northvalley the midwife responsible carried out this position alongside, another position she held and therefore struggled to manage the two:

There were lots of Band 7s [LWCs] on labour ward. They had no manager as such...everybody [the LWCS] was dipping in doing a little bit of everything and because I was there most of the time, because I was there ... I started having two office days [away from practice] where I could catch up on like all the sickness, the pregnancy assessments, and all that kind of thing, and all the audits we now have to do and it just takes up so much time.

(Yvonne B72)

One of the support mechanisms available for midwives is statutory (NMC 2012). All midwives have access to a supervisor of midwives with whom they meet annually to discuss practice and to whom they are able to access for support when required. However, at both Northvalley and Springdale there were no midwives practising on the labour ward who were supervisors of midwives and Irene (B71) suggested '*I don't think we use supervision as we [midwives] should do*' or that supervisors were '*not very visible really.*' However, it seemed apparent that the midwives may contact a supervisor '*if something has happened and you have to do a statement*' (Laura B6N). The planned removal of statutory supervision may have little impact upon these midwives. The support mechanisms that were employed will be discussed in chapter six.

The apparent disconnect between the senior midwives out-with labour ward and the LWCs as clinical leaders on labour ward suggests the lack of a strategic view or the cultural capital to influence care at other levels within the hierarchy on the part of the LWC. The symbolic cultural capital of the LWC in their immediate area appeared to be different to the capital they possessed outside it. The symbolic capital of the LWC appeared to be curtailed. Capital may be perceived as hierarchical in itself as it existed in the same form at different levels. Bourdieu (1989) suggests that:

'To change the world we have to change the ways of world making; the vision of the world and practical operations by which groups are produced and reproduced.'

(Bourdieu, 1989, p.23)

If the LWCs have little capital outside of the labour ward they may be unable to impact upon the vision of the maternity services or affect change. Fitzgerald, Lilley, Ferlie, Addicott, McGivern and Buchanan (2006) and Edmonstone (2009a) suggest that

limiting clinical leadership to being merely operational may be tokenistic and prevent clinical leaders from reaching their full potential for influencing change and facilitating excellence in clinical practice.

Summary

This chapter examined clinical leadership habitus in the field and the capital it was assigned. Clinical leadership on labour ward appeared to reside with the LWCs who possessed symbolic cultural and political capital through the compliance with their leadership and the acceptance that their central position was a fundamental requirement to facilitate the running of labour ward. The LWCs were also associated with practising in accordance with values, courage, vocation and a sense of duty to the women and may be why they were perceived to be clinical leaders. The LWCs' clinical leadership appeared to be practised in a functional, disconnected, status hierarchy. Whilst their position within the field facilitated their discretionary cultural power, it was associated with a large degree of responsibility for which they received little support and which rendered them vulnerable and culpable for labour ward practice.

Clinical leadership habitus was also associated by a few midwives with a variety of clinicians, other than the LWC and concurs with Stanley (2006) that clinical leadership exists at all levels. The lack of clarity surrounding the clinicians who were associated with clinical leadership resonates with the literature and suggests the reason for the confusion is the newness of the term clinical leadership and the lack of a clear definition. The obstetricians appeared to possess symbolic cultural capital through their responsibility for high-risk women and along with the matrons, through their elevated position within the hierarchy. The clinical leadership within the field was based on socialised relationships that appeared to impact upon the dimensions of power between the midwives and obstetricians. Symbolic violence appeared to be

present within the gendered and class relationships that were misrecognised as hierarchical deference and the possession of cultural capital. Whilst the Band 6 'Wing Man' was also accorded cultural capital it was through their clinical acumen, rather than their position in the hierarchy. The 'Wing Man's capital did not become symbolic as their position in the hierarchy was not the norm and therefore did not appear to confer them power in the field. The following chapter will explore how the LWCs employed their capital and how their habitus developed to manage the 'unsafe' field.

CHAPTER SIX: SAFETY

Introduction

It has already been established that the habitus of the clinical leader on labour ward was mostly associated with the LWC. Whilst I acknowledge that other clinicians were perceived as clinical leaders by a few midwives it is the LWC that this chapter will consider. The chapter will examine 'safety', one of the two overarching themes of the findings, with regard to the impact of the field on the habitus and capital of the LWC clinical leader. The chapter will comprise two parts; Part one will start by describing the field within which the LWCs practised and the habitus and capital that appeared to be required of them. Part two will then explore the social capital that was fostered by the LWCs and midwives as a means of facilitating midwifery practice within the 'unsafe' field and the characteristics that delineated the 'effective' clinical leader that appeared to facilitate this.

PART ONE: The Unsafe Field

Practice is situated in spaces and periods of time and although the field may not be of a person's choosing it is integral to the development of social systems (Jenkins, 2007), and therefore the behaviour within it. Whilst Bourdieu suggests that in his equation to represent his Theory of Practice, capital, habitus and field confer equal weight in the practice of clinical work and that habitus and capital impact upon the field and vice-versa (Grenfell, 2007), the findings of this thesis suggest that the field may outweigh habitus and capital as having the greater impact upon clinical practice.

'Spinning plates' and 'I think I'm going to die at work'

The labour wards at both Springdale and Northvalley appeared to be '*busy*' and '*stressful environments*' (Anita B51) where midwives were '*caring for one woman after another without rest*' (Beverley B72N) during twelve hour shifts that rendered clinical care '*relentless*'. Labour ward appeared to be unpredictable as the midwives '*didn't know what was coming through the door*' (Anita B51) and even if the clinical leader delegated the care of a low-risk woman to a junior midwife, the woman could '*still be the one [woman] that ends up in theatre*' (Alexis B71N).

Whilst the labour wards were busy, there were several occasions when I visited Springdale when there were very few women in labour (Fieldnotes Springdale, 21.02.13 am and pm, 01.03.13, 09.03.13, 12.03.13), although I recognised that my visits were snap shots of time and acknowledge there were periods of intense activity (Fieldnotes Springdale, 27/28. 08.13) when I was unable to undertake the interviews I had arranged. Amy (B62) suggested:

...having more than one woman at once, that's usual at the moment and it's just ... you feel like you're splitting yourself in two.

(Amy B62)

Whilst attempting to interview Alexis, a LWC at Northvalley I observed her being interrupted on eleven occasions before we decided to end the interview. Alexis (B72N) described the work of the clinical leader as being:

...on a hamster's wheel sometimes ... constantly running and just jump off and do something else and then you're spinning plates (laughs).
(Alexis B72N)

Yvonne (B72) suggested that midwives could be at '*breaking point*' because the busy environment was '*horrendous*' and that the clinical leader on a particular shift had been '*absolutely shattered*' as she had not had a break and was '*mentally exhausted*' through '*running from one problem to another*'. All of the clinical leaders and midwives at both Springdale and Northvalley suggested that the labour ward environment was both physically and emotionally demanding for everyone. This finding is supported by the NHS Staff Survey in 2014, (NHS England, 2015) that suggests midwives and those working in the maternity services found their work more demanding, stressful and less supportive than clinicians practising in other areas of the health service. Twelve hour shift working is commonplace within the NHS and was apparent in the study at both sites. These long shifts were introduced as a means of saving money and providing continuity of care for women over twelve hours rather than seven (Leversidge, 2013). Whilst twelve hour shifts may be preferred by some midwives as they support their child care or other caring responsibilities, there is some evidence that these long shifts may cause health problems and increase the potential for errors (National Nursing Research Unit, 2013).

Whilst much has been written with regard to emotion work in midwifery (Hunter, 2001, 2004 and Hunter and Deery, 2009), the physical nature of work does not appear to have been described, although appeared to be a feature of this field. A LWC was described as being '*unable to speak*' (Miriam B71N) at the end of a busy night shift as she was so tired. Dealing with the complexities in practice was described as '*reaching saturation point*' (Donna B72N), '*coping with the enormity of it all*'; '*hard*'

and a 'big challenge' and 'being bogged down' (June B82N); 'overwhelming' (Nicola B71N, Selma B51, Donna B72N); 'miserable'; 'one hard slog after another' ; an 'absolute nightmare' (Yvonne B72) and 'drowning', 'being stretched beyond your capabilities' (Jessica B72N). All appear to be traumatic images. Valerie suggested her practice as a clinical leader led her to think she was going to die at work:

I think I'm going to die at work (laughs) because...There was one shift, honestly, the pressure, the constant pressure every day. Because it was really, really busy and we didn't have enough staff and as well as having patients [pregnant women] myself, I was trying to keep on top of everything and support people when things went wrong in their rooms, and instrumentals [instrumental birth], trials in theatre [trial of instrumental birth] and that type of thing and keep an eye on the board [white board]; see who's coming in, who else to tell [the obstetrician, anaesthetist or paediatrician].

(Valerie B71N)

The midwives at both labour wards, although it appeared to be more common at Northvalley, used war imagery and military terms to describe the work on labour ward. They spoke about coming up 'through the ranks' (Alison B72N) (which is suggestive of a military hierarchy), having 'a foot in each camp', when referring to practising on labour ward and the birth centre (Jacqueline B82) and practice being a 'battle' (Liza B71N) and being a 'man down' (Judith B72N), when they were short staffed or that the obstetricians were 'challenging every day' (Gina B72N). Judith (B72N) suggested that facilitating normal birth for women with the obstetricians was:

It's so hard to try and keep things normal, you know, when you're the only one on and you're fighting, constantly fighting and it gets hard to constantly fight for 12 hours a day, every day.

(Judith B72N)

The obstetricians appeared to be on the opposing side in the battle, however, ironically, were tasked with the same responsibility as the midwives: that of caring for the woman and her family. The dysfunctional nature of the relationships between the midwives and obstetricians will be discussed in chapter seven. Hazel (B72N) also likened facilitating the birth of a baby when the second stage of labour was prolonged

or delivering a placenta as *to do 'battle'*. I observed a LWC at Northvalley one morning allocating the care of particular women to the midwives:

One midwife had a migraine and another, a virus and was not feeling very well. The coordinator laughed and said I can't go into battle with you lot feeling poorly! I'll have to drag your dead bodies into the rooms and say just deliver them!

(Fieldnotes Northvalley, 14.09.13).

Giving care appeared to be perceived as an armed struggle. Flint suggested in 1988, that midwives practised in an environment which often appeared unsafe; was understaffed and where midwives became exhausted. The war imagery employed by the LWCs appeared to resonate with Flint's description of the practice environment as a fearful, life and death environment. She also suggests that midwives worked in a:

'Hierarchy designed for the Army, adapted for nurses, where the thread running through the structure is that the person at the bottom of the pile will obey the orders.'

(Flint, 1988, p.25)

The symbolic power accorded to the LWCs' clinical leadership, the hierarchy and structured power relationships that I have previously discussed appear to be implicated in this busy field. Grenfell (2007, p.59) suggests that to avoid anarchy or loss of function, the field requires 'order' and 'predictability' that leadership may supply. However, a power struggle to determine whose symbolic capital was of greater consequence appeared to exist. Whilst the LWCs in this thesis did not always appear to 'obey the orders' it appears much of what Flint suggested in 1988 appeared to remain the same twenty-five years later.

The High Risk Labour Ward

The field did not only appear to be physically and emotionally demanding but also unsafe. The midwives at both Springdale and Northvalley suggested that the labour wards were becoming more high risk, in that the women they cared for were at greater

risk of complications occurring in pregnancy and during labour. The labelling of women as low and high risk has been challenged as unreliable in predicting which women subsequently experience complex pregnancies or labours (Walsh, El-Nemer, Downe, 2008), however, remains the means of determining where women receive their care in labour. I observed at Northvalley:

There were nine women on labour ward: three postnatal women were ill with infections⁹ and two with pre-eclamptic complications.

(Fieldnotes Northvalley, 02.07.13)

The increased number of high-risk women at Northvalley and Springdale reflects the trend in the maternity services that care for more women with co-morbidities that affect their pregnancies (Knight, Tuffnell, Kenyon, Shakespeare, Gray, Kurinczuk, 2015). Mackenzie Bryers and van Teijlingen (2010) suggest that risk and safety appear to have become a central tenet of care since a medical, rather than social approach to care has become more prevalent. Since the opening of the birth centre at Northvalley, although the number of rooms on the labour ward had decreased, the women were mainly high risk, except for the women who came to access epidural analgesia and the extra risk appeared to have increased the midwives' workload. Labour ward was compared to a '*medical ward*' (Frances B62, Carmen B62) which may have implications for midwifery education, in that midwives no longer enter training with a nursing background and may therefore require more instruction in nursing care. Amy also suggested:

I can see myself getting drained by the work on labour ward and would just like to see something ... something normal. Some days I don't particularly feel like a midwife (laughs). I feel like a nurse... and I'm not nurse trained¹⁰ (laughs).

(Amy B62)

⁹ Women with infections are often severely ill and at risk of dying.

¹⁰ Nurse training is no longer a pre-requisite to entering midwifery education, although some nursing skills are inherent in the midwife's role.

Northvalley appeared to care for a higher proportion of high risk women than Springdale. The difference between the numbers of high risk women at both labour wards may have been attributable to the local population that each labour ward served. Northvalley had a higher proportion (39%) of women from ethnic minority groups (Care Quality Commission (CQC), 2010a) compared to Springdale (3%) (CQC, 2010b). Ethnic minority populations are perceived to be less able to access services and to be at greater risk of complications (Knight, Kurinczuk, Spark & Brockleurst, 2009). However the midwives at Springdale were also experiencing an increase in the number of high risk women they cared for. Florence posited:

The women we're receiving now are so...they are diverse and the complications we're experiencing... I feel at times it can feel obstetric rather than midwifery.

(Florence B71)

The high-risk nature of the field appeared to legitimise the need for a clinical leader and therefore the cultural capital the LWC possessed through her position as leader became symbolic through the perceived necessity. Hannah who was practising on the ward at the time suggested that:

Well, it's [labour ward] a much more high-risk area. It's much more active in a way than the wards ...so I think they [the LWCs] need to be there because that's where you probably need the most leadership and they're [LWCs] really taking charge.

(Hannah B52)

A high-risk ward appeared to represent more danger and risk which may have caused more anxiety with regard to the midwives accountability and an enhanced tendency to submit to the leader being in charge. Anita (B51) suggests that there was more responsibility inherent for the clinical leader in the number of high-risk women on labour ward:

Obviously she's [LWC] more responsibility for more high risk women, but then you don't know what is coming through the door... if it's more high risk definitely puts more stress on them.

(Anita B51)

The extra responsibility attributed to the LWC suggested she had taken on some of the obstetrician's responsibility for the care of high-risk women. Bourdieu and Wacquant (2002, p.130) suggest that 'resignification' may occur when a person discards something that symbolises their domination. Ironically the resignification of the LWC as being responsible for the high-risk women on labour ward may be perceived as discarding midwifery practice and submitting to the medical discourse which symbolised their domination by the obstetricians. However, being immersed in high-risk care may have affected the LWCs' perception of what 'normal' is over time. Assuming responsibility for the care of high-risk women suggests the advancing practice of the LWCs is associated with the development of medical rather than midwifery skills that may be a threat to effective clinical midwifery leadership. However, as I have already suggested, the LWCs also continued to promote practices that facilitated normal birth that may be construed as resistance. Their involvement in supporting high-risk birth may have equalised the balance of power in their favour, although lessens the unique skilfulness and knowledge of the midwives. Bourdieu and Wacquant (2002) suggest that submission and domination are paradoxically inter-related, in that resistance always complies with power.

The Field Structures Habitus and Capital

Bourdieu (1992) suggests that the field structures habitus in that it provides for its realisation: the field is the habitus' place of embodiment. A person's habitus and behaviour becomes apparent in relation to the situation she/he finds her/himself in (Grenfell, 2007). The LWCs' clinical leadership habitus and capital appeared to have developed to enhance safety in response to the unsafe field.

'Your Port in the Storm': Heroic Leaders and Cultural Capital

Clinical credibility appeared to be an essential requirement of the LWC clinical leader which reassured other midwives of their safety. Tourish (2013, p.15) suggests that

credibility is a 'key ingredient' of authority. The LWCs were perceived to have a large amount of clinical experience and knowledge, and therefore cultural capital. Practical knowledge and clinical credibility appeared to be more highly prized by many of the midwives, than other forms of knowledge, such as academic knowledge that was also evident in the literature (Christian & Norman, 1998, Cook, 2001a, Connelly et al., 2003, Donnelly, 2005, Stanley, 2006, Redwood et al., 2006, Burns, 2009a, Carryer et al., 2007, Manley et al., 2008, Gould, 2008, Mayo et al., 2010, Mitchell et al., 2010, Mcnamara et al., 2011, Martin & Waring, 2012, Matthew-Maich et al., 2012, Elliott et al., 2012, Wickham, 2013). Eve (B62) suggested the LWCs possessed '*the knowledge that comes from experience rather than, you know...books*', which may have related to the practical rather than academic nature of the work involved on labour ward. Although, I suggest a mixture of the two may be required to facilitate effective care giving in practice. Irene (B71) suggested that Valerie, one of the LWCs, '*knew everything*' and Selma (B51) suggested:

Experience is a big thing, just because they have seen lots of things and that helps doesn't it? If they have experience that is such a big thing in leadership.
(Selma B51)

Many of the LWCs associated their clinical ability to being credible in practice. Being unable to undertake the more complex practical tasks themselves meant that they would not be in a position to support other midwives with these tasks and potentially unable to lead. Gina suggested:

I can't expect others to do it if I don't do it myself.
(Gina B72N)

The LWCs were perceived to be those most able to manage an emergency situation, such as being the 'Placenta Queen' (Nicola B71N) as they were able to remove a placenta that appeared to be retained in the uterus (Leslie B71N) or being the 'third instrumental delivery' (Hazel B72N) in that the midwife was able to facilitate a vaginal birth without resorting to instruments, such as forceps. The LWCs appeared to have

developed skills that appeared to be within the remit of the obstetrician, (although midwives are expected to possess the skills to facilitate breech birth), which may have enhanced their cultural capital by association. I observed Gina (B72N) at Northvalley demonstrating her advanced skills when she facilitated a breech birth with another midwife. She described the birth as:

The vaginal breech this morning you know, it was like it was nice but you know it was a little bit hairy at one point ...the [baby's] head got stuck...she [the woman's cervix] wasn't quite 'fully' [dilated] but she was a multip [multigravida] so I managed to push it back but when it came out it [the baby] was a little bit you know [required resuscitation].

(Fieldnotes Northvalley, 28.07.13)

Gina (B72N) suggested that midwives became anxious if the LWC was perceived as not knowing what to do:

I remember once, it was a while ago, and I said, "Oh Christ, I don't know what to do" ...and this midwife turned to me and said, "Oh Gina if you don't know what to do!" and I thought, oh, I shouldn't have said that. I said, "Oh, no, no, just let me think". You're always expected to know what to do.

(Gina B72N)

The expectation and acceptance that the LWC knew what to do appeared to confer her symbolic cultural power which may have been more significant in an unsafe and chaotic environment. The reliance upon the LWC to know everything may have disempowered the other midwives practising on labour ward. However, the LWCs' knowledge of the management of complex situations appeared to facilitate other midwives to gain these clinical skills: Gina (B72N) *empowered and supported the learning of a more junior midwife in the facilitation of a breech birth* (Fieldnotes Northvalley, 28.07.13) and Nicola (B71N) *supported a newly qualified midwife to care for a woman having a significant blood loss following a caesarean section* (Fieldnotes Springdale, 04.10.13).

The deferral of responsibility to the LWC, however, suggests that fear was sometimes associated with practising on the labour ward. Beverley (B72N), one of the nominated clinical leaders at Northvalley suggested that some midwives are afraid and that:

I think sometimes you walk in the room as a senior midwife and they want to abdicate all responsibilities. I remember being that junior midwife and thinking, thank God she has walked into the room. Amongst all the stress they [LWCs] are like your port in the storm.

(Beverley B72N)

The perception of the LWC as 'a port in the storm' is reminiscent of the powerful, heroic, male leader arriving to save the day and taking responsibility for everyone, rather than a more democratic, clinical leadership aimed at empowering everyone to support and enhance effective practice. The risk apparent within the labour ward environment may have led to the desire for an all-knowing, heroic clinical leader. Bourdieu suggested that heroism is a professional form of political power that requires 'collective trust' and 'reputational capital', (Swartz, 2013, p.66) that the LWCs appeared to possess. Heroes are more likely to emerge in times of crisis which may explain why the LWC as a hero was welcomed by the other midwives. However, the heroic leader appears to be the antithesis of what the drive to enhance clinical leadership at the front line of care purports to be and may suggest that the labour ward environment may not support its development.

The LWC being a saviour was echoed by some of the other midwives who suggested that when the LWC entered the room they were '*relieved*' (Adele B51), thought, '*thank goodness it's you*' (Grace B62), and '*I'm glad she was there*' (Stephanie B61). The LWCs clinical leadership may have been construed as a form of advocacy or matriarchy for the midwives on labour ward. Both advocacy and matriarchy suggest someone is being cared for and implies the involvement of power relationships and a lack of agency. Hayley (B61) suggested:

She's [the LWC] good for the midwives. She will stand and watch your back all the time. So when you're on shift with her you feel confident that, that there's somebody there. That you know that if the shit was going to hit the fan she would sort it.

(Hayley B61)

The possession of symbolic cultural power may have been required by the LWC to 'sort it'. Advocacy may also be associated with the notion of safety. Having someone

'watch your back' implies the existence of a protective mechanism to either facilitate the avoidance of mistakes or to defend and support when outcomes were not favourable. This may have enhanced the midwives feeling of security and facilitated a sense that they were able to practice confidently.

The LWCs were perceived to have strong characters so that they were able to advocate for women and midwives with the obstetricians. Having a strong character appeared to be a prerequisite for a LWC as they were viewed as being more accountable:

They might be more likely to get questioned than the practitioner and are going to be more accountable. If there's a problem they will be the ones coming in and taking control of the situation and also there might be getting a bit of conflict or it may be too busy, they might be able to deal with conflict... they have to be strong characters to be able to cope with that.

(Emily B52)

The LWCs' clinical acumen and the fearful labour ward may be why the LWCs were perceived to have more leadership responsibility. Kirkham (2011) suggests that fear has a corrosive effect upon the confidence, performance and happiness of all involved in care giving. However, the LWCs maintained safety and reduced the fear. Sinek (2014) suggests that it is only when we perceive we are in a 'circle of safety' (p.22) we pull together as a unified team, better able to survive and thrive regardless of the conditions outside. Inside the circle you are safe but outside there are dangers. He also suggests that exceptional organisations have cultures in which the leaders provide 'cover from above' (Sinek, 2014, p.8) (which may be reflected in the supernumerary overseeing status of the LWC) and the 'people on the ground look out for each other'. He suggests this type of cover and team work facilitates a willingness to work hard and take the kinds of risks they do (Sinek, 2014). This may imply that in a 'risky' environment midwives may be better able to practice if the cover from the LWC is in place. The LWCs' symbolic cultural capital and subsequent power over others, whilst recognised as being valuable for keeping labour ward safe, may

be warranted in such fields. However, as I discussed in chapter two, the midwives practising in hospital labour wards may perceive birth to be inherently risky rather than seeing birth as normal and dealing with risks as they arise. Midwives may therefore avoid undertaking any form of risk. Having the appropriate cover and support may address this.

Control and ‘Keeping a Finger on the Pulse’

Being in control appeared to be associated with the LWCs symbolic cultural capital, embodied in her position and responsibility for keeping labour ward safe. Although Stephanie (B61) suggested that the LWCs’ control was related to keeping labour ward ‘*low risk*’ and ‘*as safe as possible, without always getting the doctors*’, she suggested some LWCs were akin to ‘*Rottweilers*’ in their approach to it. Stephanie (B61) suggested that the LWCs controlled the environment with regard to the involvement of doctors and this will be explored in chapter seven when I examine the LWCs’ struggle to maintain their professional identity as midwives. The LWC was ‘in charge’ of her shift and her¹¹ remit was to facilitate the safety on the labour ward by distributing the care of women and their families to those with the appropriate experience; coordinate the care of the women alongside the availability of staff and beds. I observed this practice on every occasion I went to both labour wards.

Whilst I have already suggested a degree of cultural capital may have facilitated the LWCs’ ability to coordinate care, there were other characteristics that were associated with their clinical leadership. The majority of the midwives perceived ‘overseeing’ to be an important aspect of the LWCs’ responsibility which legitimised the practice and gave the LWCs symbolic power to enter the rooms where women were being cared for. Overseeing related to:

¹¹ I refer to ‘her’ as all the midwives at Northvalley and Springdale were female, although I recognise that some midwives are male.

Entering the rooms where midwives were giving care to women to ensure all was well or expecting midwives to report back on women's progress in labour.

(Fieldnotes Springdale, 03.03.13 and Northvalley 12.04.2013).

The LWCs described their need to 'keep a finger on the pulse' as being associated with facilitating safety. Yvonne suggested:

You've got to have a finger on the pulse all the time haven't you, to keep it safe... because at the end of the day being safe is the most important thing.
(Yvonne B72N)

The LWCs at both sites were not allocated to care for women to facilitate their availability for advice and support for others and to coordinate activities. They situated themselves centrally on labour ward in the office so that other healthcare workers were able to access them and report back more easily:

Whilst in the office, which was where Beverley stayed mainly... she was informed of a woman's raised blood pressure.
(Fieldnotes Northvalley, 04.06.13)

Ropo, Salovaara, De Paoli and Sauer, (2015) suggest that places and space may construct and perform leadership. The labour ward office may have also transformed the dynamics between the LWC who occupied it most frequently and the midwives in a subordinate position who reported and accounted for themselves there. Through Bourdieu's Theory of Practice lens the office and the overseeing of midwives may be perceived as instruments of domination. The position of the LWC on the labour ward was reminiscent of the 'Panoptican' described by Foucault (1991, p.201) as an architectural structure designed to facilitate the surveillance of prisoners. The Panoptican had a central tower (that may be substituted for the Labour Ward office) that overlooked the prisoners who were exposed to surveillance, which was antithetical to the dungeon that removed prisoners from view. Foucault (1991) suggested that the Panoptican epitomised the perfection of power over others as it rendered the actual exercise of power unnecessary. The presence of an observer

and being exposed to observation may render those who are observed to monitor their own behaviour.

The behaviour of the midwives was not only influenced by the centrality of the LWC but also the symbolic cultural capital she possessed that imbued a sense of responsibility in the midwives to update her with regard to the progress in labour of the woman or women in her care. Reporting back and being observed by the LWC appeared to be a necessary prerequisite to facilitate the LWC to coordinate labour ward activity. The midwives reported back to the LWCs on a regular basis at both Northvalley and Springdale and suggested that the midwives familiarity with labour ward practices and the rules of the game influenced their deference to the LWCs. Lovelace, Manz and Aves (2007) suggest that control is important in increasing productivity as well as reducing stress. Although I have suggested that domination may be at work in the field there appeared to be some reciprocity involved in the reporting back process in that the LWC was aware of labour ward activity and the midwives were given assistance should it be required. A junior midwife:

...spoke to another LWC about her query and seemed happy with the answer as she went back into the woman's room.

(Fieldnotes Springdale, 21.02.13)

Although some of the LWCs seemed happy to wait for the midwives to update them, the majority needed to know what was happening in every room, which suggests a degree of anxiety on their part. The rationale for this, however, was associated with trust:

I want to know that they (midwives) are recognising abnormalities and they are able to tell me why they want me to come in (Valerie B71N) and that the women were 'managed appropriately.

(Judith B72N).

Valerie (B71N) suggested that once she was assured that midwives could be '*trusted*' she was able to oversee them less. Whilst Ham (2003) and Edmonstone (2009a) suggest that clinicians at the front line of care have the potential to be the most

powerful in the hierarchy through their ability to resist or not comply with normative practices, most of the midwives appeared to 'report back' to the LWC. Bourdieu suggests that a logic of practice exists and that people understand how to behave in the field due to the socialisation of the practices that takes place over time (Grenfell, 2007). Bourdieu used the metaphor of a game to describe the tacit rules of the field that are developed by the players of the game through which practices are developed (Swartz, 2013). The practice of reporting back to the LWC appeared to be constructed by the LWCs' symbolic cultural capital and the midwives' feel for the game. Clinical leadership appeared to be arbitrary in the sense that the midwives followed, although they appeared to be aware of their followership driven by fear and their reliance on the strong women who kept them safe. Swartz (2013, p.120) suggests that Bourdieu does not examine 'power over relationships' that produce benefits for a subordinate. It appeared that there was some benefit for the midwives in the LWCs' power over them as it afforded a degree of safety for themselves and the women for whom they cared.

The Visible Leader

The LWCs' presence on the labour ward appeared to reassure the midwives on both labour wards and subsequently enhance the LWCs' symbolic cultural capital. The LWC was perceived as someone who supported and advised other midwives. Anita suggested:

Having somebody there, for support even if they're busy with somebody else, you know that they're [LWCs] there and you know you can just go and ask them something. You can tell them what's happening and they're on the spot. Whereas with a doctor you've got to bleep them and they might be busy on gynaecology or something like that. Even if there's an emergency they [the doctors] might not be immediately available.

(Anita B61)

As I have suggested previously the LWCs were sited centrally on labour ward to facilitate other midwives' access to themselves. However, several midwives at both Northvalley and Springdale suggested that some of the LWCs remained office based,

and were not proactive in assisting midwives to facilitate care. The behaviour was perceived by some midwives as the LWC '*not being interested*' and sometimes left them feeling '*less confident*' (Frances B62). The midwives on both labour wards appeared to prefer those midwives who were more actively involved in care. It appeared that whilst the symbolic cultural capital associated with the acceptance of the LWCs' position was sufficient to ensure that the midwives kept her informed, it was not enough to reassure the midwives about their own clinical practice, and suggested some fearfulness on their part.

The LWCs visibility also facilitated other midwives to determine the extent of the LWCs cultural capital through being able to acknowledge and respect the LWCs' clinical skill. Stephanie suggested:

I personally like them [LWCs] to be involved. I feel if I am going to someone for advice or support, I want them to advise and support me properly, not just sit in a room. How can they say you need to go to a doctor for suturing if they haven't even seen it, you know?

(Stephanie B61)

The midwives who were more actively involved in care were perceived to be the '*better*' (Hayley B62) LWCs. The cultural capital afforded to those LWCs who were less visible appeared therefore to be reduced. The midwives preferred to work with someone who '*pitched in*' and worked as a member of the team (Frances B62). Being visible and active in clinical practice was perceived to be valuable. It meant the LWCs who were involved in guideline writing and making decisions with regard to the unit were able to understand the reality of practice and those midwives practising within it. The value placed upon the LWCs visibility appeared to resonate with the clinical leadership literature (Ham, 2003, Davidson et al., 2006, Edmonstone, 2009a, Casey et al., 2011) in that the clinical leader's position close to practice is one of its strengths, in that it may affect the giving of direct care. Being removed from practice was associated with losing sight of what happened clinically. The LWCs may have been more able to represent the midwives' views, as they understood *what was*

'going on, on labour ward' (Carmen B62) and how change impacted *'care-giving'* (Selma B51). The midwives perceived that this kept them *'up to date'* and gave them *'more say'* in any changes that occurred (Marion B51). However, as I suggested in chapter five the apparent lack of contact with and support from the managers may have limited the strategic influence that the LWCs possessed and therefore trust in this aspect of the LWCs' capacity may have been misplaced.

As well as being employed to retain control of the field the LWCs appeared to use their cultural capital in positive ways. Being approachable was something that the midwives perceived to be important and was a characteristic of most of the LWCs. The approachability of most of the LWCs may have been facilitated by their visibility and associated with safety and productivity. Being able to ask questions without the fear of feeling *'silly'* (Grace B62) reassured midwives that they could ask for advice with regard to women's care that may have enhanced safety. Being approached often resulted in learning as the LWCs did not resort to giving a definitive answer to the questions but facilitated the midwives to make their own decisions, as Selma (B51) suggested:

They (LWC) will try and encourage you to like, make a plan and then will agree it or offer some different advice, rather than saying you need to do this.
(Selma B51)

I observed this on several occasions and this kind of support was illustrated at Springdale when:

A junior midwife was asked by the Acting Band 7 Midwife "What is happening with the woman you are caring for?" Once she had given a resume she was asked "what is your plan?"

(Fieldnotes Springdale, 21.02.13)

The LWCs being approachable and accessible appeared to facilitate effective decision-making and practice as it facilitated other midwives being able to access the LWC for advice or assistance if it was required. Adele (B51) suggested *they [the LWCs] are 'all approachable so you can ask them for advice': 'you never feel like you*

are on your own' (Marion B51). Although the less experienced midwives appeared to value the LWC being approachable, not all of the LWCs appeared to be so. Some LWCs were '*grumpy*' and '*bad tempered*' (Judith B72N). Liza (B72N) suggested that the hierarchy may have been responsible for clinicians being either, unapproachable or to have an unapproachable senior position:

It used to be a very formal hierarchical structure and now, even though there is a hierarchy to a degree, it's not the same formality, it's good. People are more approachable but because you are more approachable, you can't lose that discipline, so it's getting that balance.

(Liza B72N)

It appeared that in the past the enhanced cultural capital afforded to the LWCs near the top of the hierarchy was associated with being less available and disciplinary. Changes in the hierarchy impacted on the LWCs' clinical leadership by creating a balance between being approachable but maintaining discipline and also being perceived to be '*soft*' or '*hard*'. The duality required of the clinical leader is reminiscent of the practice nurses in Burns's (2009, p.467) study who suggested that the clinical leaders were '*professional, yet human*'. Being '*soft*' (Miriam B71 and Karen B71N) appeared to signify weakness in their clinical leadership and may be related to the development of a masculinised form of clinical leadership. Both Miriam (B71N) and Karen (B71N) suggested '*being soft*' was related to '*being nice*'. Although they perceived that being nice did not mean they were unable to maintain '*high standards*' of care, their defence of being nice suggests that the consensus may be that '*being nice*' was incompatible with high standard setting.

Mackenzie Bryers and van Teijlingen (2010) suggest that the main difference between the social, midwifery and the medical model of care rests in gender-based practice that suggests midwifery and nursing are female and medicine is male. It appeared ironic that the LWCs, as midwives and women were concerned about demonstrating feminine characteristics. However, Bourdieu suggested that the dominant perceptions of the social order, that tend to be masculine, in society and

social behaviour may be accepted and transferred into the workplace (Lawler, 2004) and become part of the habitus and culture. Oakley (1993), although referring to nursing, suggests that for nursing to reach its professional status it may have to lose its femaleness as the dominant values appear to suggest that caring is unimportant work. Adopting a more masculine approach may be viewed as enhancing the importance of caring within the dominant discourses and enhancing cultural capital. However, Mackenzie Bryers and van Teijlingen (2010) suggest that it may be naïve to assume such a simple divide between the genders of a doctor's or midwife's practice. Walsh and Newburn (2002) suggest that the doctor and midwife sit somewhere in between the male-oriented medical model at one extremity and the female oriented social model at the other. The LWCs appeared to have a dilemma in that although they and the midwives perceived softness and approachability to be important, their culture suggested that it was not. It may have been necessary to be recognised as clinical leaders on the labour ward that the LWCs had to strike a balance between the two to preserve their credibility and cultural capital in the field.

'Scary'

The midwives on both labour wards suggested that some of the LWCs were perceived to be scary: '*scary but a good leader*' (Fieldnotes Springdale, 29.09.13). It was acceptable for the habitus of the LWC to be intimidating or scary in the pursuit of safety on labour ward. Leslie (B81) suggested of one of the LWCs at Springdale:

I just trust her to make the right decision. She'd probably upset a lot of people with what she says or does but in an emergency I know she'll be safe. So if she's a bit off and arsey [bad tempered/uncooperative] with people I haven't got a problem with that cos she's going to save the day.

(Leslie B81)

The LWC Leslie referred to was Nicola (B71N) who was nominated by several midwives as being an effective clinical leader and the suggestion is that her 'scariness' was valued and therefore had the potential to be learned and perpetuated. It appeared that for the sake of being safe any type of behaviour was acceptable.

Symbolic cultural capital was afforded to those LWCs who demonstrated scary behaviour. The two LWCs who were most nominated as 'effective' clinical leaders (Nicola (B71N) at Springdale and Gina (B72N) at Northvalley) possessed this characteristic amongst others. I described Nicola's aggressive behaviour in chapter four (p.103) and had worried about interviewing her. However, Nicola (B71N) suggested that one of the reasons she had to be strong was that:

It [labour ward practice] wears you down sometimes (laughs) but sometimes he who shouts loudest gets heard.

(Nicola B71N)

Nicola (B71N) also suggested that being a '*watch dog keeps people safe*' or a '*Rottweiler*', as Stephanie (B61) had previously described her. Gina (B72N) stated that she may be '*short with people and I've always tried to pull myself upon that*'. However, she perceived '*if you're fair with people it will go a long way*'. They were both fair but firm which appeared to be respected as they were perceived to be 'effective' clinical leaders. However, there were some LWCs who demonstrated bullying behaviour, as they made '*sarcastic comments*', '*rolled their eyes or made midwives feel stupid by asking them [junior midwives] questions and trying to catch them out*' (Stephanie B61). Bullying characteristics were not associated with 'effective' clinical leadership. Some of the LWCs' behaviour appeared to be reminiscent of the horizontal violence associated with inter- group bullying which Leap (1997) suggests:

'Embodies an understanding of how oppressed groups direct their frustrations and dissatisfactions towards each other as a response to a system that has excluded them from power.'

(Leap, 1997, p.689)

Whilst the LWCs were not excluded from power, their power was discretionary which facilitated their ability to control and protect the environment. However, the overwhelming nature of their work and a lack of hierarchical authority beyond the maternity unit appeared to inhibit them being able to change their circumstances.

The scary or bullying behaviour may be perceived as a mechanism the LWC employed to cope with their heavy work load that has already been described. However, it prevented midwives approaching the LWC for advice, which may have reduced the LWCs workload but had the potential to lead to inappropriate care being given to women and therefore is ironically less safe. Hayley (B61) rationalised the LWCs' poor behaviour to the 'busyness' of labour ward and the number of newly qualified midwives they had to support.

Well, I think, sometimes, some of the Band 7s, they're verging on bullying. You see the way people talk to people and you think that is sort of pushing...no that isn't bullying but it is pushing towards it...I think the Band 7s [LWCs] get frustrated because they're starting to run a shift and you've got all these midwives and if your skill mix is rubbish then you're stuffed. I mean the other day, there was one Band 7 [midwife], a Band 6 [midwife] and four newly qualifieds [midwives] and that's crap... and so the Band 7s [midwives] are stressed because they're thinking about the skill mix; thinking I haven't got anybody here if I get anybody really, you know, complex. Then they're [LWCs] sharp with everybody.

(Hayley B61)

Valerie (B71N) also suggested that the LWCs may not appear as welcoming to people who visit the labour ward because of the '*stresses and strains*' of her work. My experience of the reticence that the heads of midwifery demonstrated with regard to how I would be received by the LWCs when entering the field suggested this group of midwives possessed a reputation for being intimidating. Although I was unsure whether being 'scary' was a sign of strength and power, I perceived it to be so.

The poor behaviour was occasionally referred to as '*old school*' (Jessica B72N, Denise B72) which suggests that the behaviour was socialised: it was something that had been happening over a long period of time. The LWCs being '*good at their job*' appeared to be one of the reasons why the LWCs' poor behaviour was '*let slide [ignored]*' (Beverley B72N). The acceptance of this type of behaviour was identified by Curtis, Ball and Kirkham in 2006 when they examined why midwives left midwifery. They found that 'inappropriate behaviour was condoned, for fear of upsetting the perpetrators who played a key clinical role' (Curtis et al., 2006b, p.218). Jessica

(B72N) suggested midwifery was '*notorious for having stroppy individuals*' and that if it remained '*unchallenged*' it '*breeds*' further poor behaviour. The socialised nature of the LWC habitus will be explored in chapter seven. However, Beverley (B72N) suggested that the unsafe field appeared to support and perpetuate the cultural LWC habitus:

How do you break a culture when you are in a very high stress and high risk environment and you need those people to be doing their job well? Because if you don't, at the end of the day women and babies suffer.

(Beverley B72N)

The field appeared to limit the LWCs and other midwives' ability to address poor behaviour as the skills that these midwives possessed held symbolic cultural capital due to the perception that they were integral to the maintenance of safety. The scary type of clinical leadership appeared to be accepted as a way of saving the day by any means to facilitate safety and reflected the outcome driven medical mode of care. However, scary behaviour may have been employed by the LWC as a means of extending their cultural capital and of protecting themselves from the demands made on them by other midwives. Whether this remains acceptable in a modern healthcare system that values effective relationships and teamwork is debatable. As will be seen later in this chapter, although the LWCs appeared to navigate between being soft and hard, being approachable, and maintaining some distance: being approachable and possessing more feminine, transformational leadership characteristics appeared to be what delineated the 'effective' LWCs from the rest.

The 'Game Face'

The labour ward environment at both Northvalley and Springdale appeared to warrant the LWCs to develop a dissembling habitus in an attempt to control the 'game' and hence the behaviour of other midwives in the field. As we have already seen the LWCs' control of the environment (by knowing what is happening everywhere), managing unpredictable situations: and having the clinical expertise to manage the

emergencies reassured other midwives and resolved their fears. The LWCs also possessed an ability to keep others calm:

....even when it's really bad...busy and there's everything going on they [LWCs] never seem to get flustered or lose it. You feel safe. You feel like nothing bad is going to happen (laughs). It's really reassuring.

(Amy B62).

The habitus of the LWCs in emergency situations was related to having a 'game face', 'poker face' (Beverley B72N), 'mask' (Gina B72N) or 'professional face' (Valerie B71N). The 'game face' was related to the LWC taking control of the situation; putting her 'in charge hat on' (Emily B52) and in an emergency situation employing a 'formal' (Alexis B71) style of leadership to get the job done and avoid others panicking. Jessica (B72N) related this behaviour to Rudyard Kipling's poem 'If' and explained that there may be some kudos associated with it or perhaps related to the adoption of masculine behaviour.

'If you can keep your head when all about you
Are losing theirs and blaming it on you...
Yours is the Earth and everything in it,
And which is more you'll be a Man, my son!'

(Kipling 1895)

However Gina (B72N) suggested that her 'game face' related to keeping others calm and hiding her true feelings with regard to the situation:

You've got to be that actress. You've got to have a smile on your face...to put that mask on. You're the leader of the ship aren't you and you've got to like, keep everybody going haven't you? Even though, I mean, I come out of rooms sometimes and I think Christ almighty...but then you go in again and smile.

(Gina B72N)

Many of the LWCs who were nominated as 'effective' clinical leaders concurred with Gina (B72N) when they suggested that although they appeared calm outside, inside they were 'dying, stressed and terrified' (Valerie B71N, Karen B71N, Judith B72N), or 'like that swan, legs going under the water but I think outwardly you should appear

calm and not flustered because that's one way of setting an example really and showing you're under control' (Sylvia B71N).

Beverley (B72N) described one of the LWCs '*crying in the car*' as a way to deal with her emotion when she was first appointed in the position. The midwives on both labour wards dealt with unanticipated emergencies, such as *shoulder dystocia of a baby at birth* (Fieldnotes Northvalley, 02.07.13), the '*death of a baby*' (Selma (B51), or *life threatening maternal blood loss following the birth of the baby* (Fieldnotes Springdale, 04.10.13). Midwives, as health professionals may therefore be perceived to be on the 'sharp edge' as they 'deal with life and death situations' and the profound emotional responses associated with this, such as joy, fear, relief, anxiety and anticipation (Deery & Fisher, 2010 p.279). Gina (B72N) suggested that her practice relied upon her performance of emotional labour that has been described by Hochschild (2003) as the emotional management that is a requisite for paid work. By stifling her true feelings Gina (B72N) was able to influence others do the same, although she suggested that others may perceive this as being '*cold*'. Gina (B72N) appeared to define the rules of the game through role modelling the accepted behaviour in particular circumstances. The symbolic cultural power she possessed as the LWC (through her position and ability to keep others safe) meant that other midwives unquestioningly followed her lead. Goffman (2001) suggests something similar in that:

'The control of others is achieved largely by influencing the definition of the situation which the others come to formulate, and he [she] can influence this definition by expressing himself [herself] in such a way as to give them the kind of impression that will lead them to act involuntarily in accordance with his [her] own plan.'

(Goffman, 2001, p.176)

Contingency or situational leadership theory suggests that accurate accounts of the context of a situation are central to the decision making that subsequently occurs.

However Grint (2005) suggests that the accounts of the context do not always explain the subsequent behaviour of the leader. Grint (2005) suggests that it is assumed that those leaders who are perceived to be successful are those who react appropriately to a specific situation: Bourdieu would suggest they are experts at playing the game. When the environment is non-threatening and otherwise calm, leaders can afford to be democratic with regard to how they approach decision making. However:

‘When a crisis occurs the successful leader must become decisive, demonstrate a ruthless ability to focus on the problem and to ignore the siren calls of the sceptics or the cynics.’

(Grint, 2005, p.1)

The leader must be confident with regard to the course of action to take and use her/his symbolic power to pursue it. An emergency appeared to legitimise the use of a specific form of authority, that of command and the use of symbolic power. Grint (2005) suggests that should a commander depict a situation as urgent or critical and subsequently resort to questioning others or asking for advice she or he may be viewed as unsuccessful. However, if a more democratic style of leadership existed the team may be consulted in a process of decision making that has the potential to be safer, as not only one person (who may be wrong) is delegated to this task. It may also lead to shared responsibility and take the onus away from the leader. The speed necessary for decision making in an emergency, however may render democratic decision making difficult.

The need of the LWCs to adopt a different habitus in different situations may contribute to explaining their dilemma with regard to being ‘soft’ or ‘hard’. Critical problems and therefore emergencies are often associated with coercive compliance and may require the LWCs’ use of the symbolic cultural power invested in their position and clinical knowledge. Midwives may allow themselves to be commanded by others who are able to successfully manage the emergencies, if they feel unable

to do so themselves. Here again there may be some benefit to the midwives of someone having power over them.

Grint (2005) also suggests that people who make decisions have more influence on the context within which they exist than conventional situational theory supports. He suggests that the ability of the leader to persuade others of the context of a situation may legitimise the leader's preferred course of action, rather than what the situation actually requires (Grint 2005). Although the LWCs were unable to take courses of action, other than what were required to manage the emergencies, it may be suggested that the midwives employed their game face in an attempt to persuade other midwives that the situation was manageable (even though she may not have perceived this herself in the moment). The LWCs' clinical leadership habitus and symbolic power appeared to re-contextualise or downgrade situations in a move to manage them more effectively, keep others on board and to feel safe..

Being an actress suggests the presence of an audience. Valerie (B72N) referred to this when she stated:

You know, people watch what you do all the time, whether you are frowning because you are concentrating; how you speak to people; the expressions of our face; how you communicate with doctors; how you communicate with the domestic and everything you do all the time.

(Valerie B72N)

There appears to be some irony in that those LWCs who are overseeing the actions of other midwives and possess symbolic cultural capital, are themselves overseen by the midwives they oversee. This suggests that the nature of the labour ward environment is one in which all the actors are observed and have the power to influence one another's habitus. The reactions of others to a person's leadership appeared to modify leadership behaviour.

The LWCs appeared to be not only managing their own emotions but employed the social capital inherent in their relationships to contain the emotions of others. Deery

and Fisher (2010, p.270) borrowed the expression of 'Philanthropic Emotion Work' from Bolton's (2005) typology of emotion management in organisational contexts to reflect the potentially motivating and celebratory aspects that may be derived from emotion work in midwifery, such as the joy associated with birth. I suggest that this term may also be employed to describe the actions of the clinical leader on labour ward who is able to put on her '*game face*' as a means of creating feelings of security and confidence that appear to facilitate effective care giving in crises. Whether the LWC was driven to dissemble by a true sense of philanthropy, in the sense of having a love for the midwives and being a benefactor for others or by the pressure of meeting organisational goals and reducing the chance of being blamed for poor outcomes was not clear. However relationships, teamwork and social and emotional capital that was developed in the field will be explored in Part Two of the chapter.

Summary

Part one of this chapter examined the perceived unsafe field and the manner in which it structured the habitus and capital of the clinical leadership of the LWC. The busy, unpredictable, high risk nature of the field appeared to render midwifery practice within it unsafe and to indicate the requirement for strong clinical leaders who possessed symbolic cultural capital to keep the field safe. The cultural capital the LWCs possessed became symbolic as the midwives accepted their authority in the fearful field. Whilst Bourdieu has not described the benefits of a power-over relationship, it appeared that the more junior midwives in the field welcomed and benefited from the LWCs' cover and circle of safety. However, as we shall see in Part Two, the midwives' deference to the LWC appeared to impact upon their agency in the field.

The LWCs' habitus developed in response to the field. What appeared to be required of the LWCs was that they were clinically able, controlling, approachable, visible, and

heroic leaders who always knew what to do to keep other midwives safe. It has been suggested that heroic leaders emerge in times of crisis and this may have rationalised the midwives' deference. The field rendered scary, masculinised leadership LWC habitus acceptable and enhanced the symbolic cultural capital that was required. The scariness of the LWCs appeared to be in response to stress, their workload and responsibility. Whilst not associated with 'good' clinical leadership, bullying appeared to be a feature of some LWCs and is not acceptable in today's NHS. The field facilitated an industrial model of care that was driven by the workload and worries about safety. Therefore, safety, rather than relationships was most important. It appeared that the LWCs had to strike a balance between being scary and approachable and employed philanthropic emotion work to facilitate effective clinical practice. However, clinical leadership appeared to impact on the physical well-being of the LWC which is an area that has not been well documented in the literature. Heroic leadership appears to be the antithesis of what clinical leadership is purported to represent as it invested the leader with the most power. It could be suggested that within such an unsafe field a more democratic form of clinical leadership may not be conceivable. Part two of this chapter will now explore how the habitus and capital of the LWC clinical leader impacted upon the unsafe field.

PART TWO: Habitus and Capital Structure the Unsafe Field

Part one of this chapter examined how the field impacted upon the habitus and capital of the LWC. Although I have suggested, contrary to Bourdieu (1992), that the field had a greater impact upon clinical leadership practice than both habitus and capital, the habitus and capital of the LWC appeared to have some influence on the field. Part Two of this chapter will explore the habitus of the 'good' LWC clinical leader; her influence, practice and how the relationships with other midwives facilitated the development of social and economic capital to facilitate midwifery practice in the unsafe field.

The Development of Social Capital

'Interaction enables people to build communities, to commit themselves to each other and to knit the social fabric. A sense of belonging and the concrete experience of social networks (and the relationships of trust and tolerance that can be involved) can, it is argued, bring great benefits to people.'

(Tittenbrun, 2014, p.454)

Bourdieu conceptualised social capital as reflecting the possible advantages to people or groups of people from their combined resources (Swartz, 2013), such as the generation of goodwill, camaraderie, empathy and social intercourse among those who comprise a social unit. Social cohesion is required to facilitate the prosperity of societies and social interaction facilitates the development of communities who commit themselves to each other and to build the social structure (Putnam, 2000). The term social capital describes the benefits that result from a person's social relationships and although there are other views ascribed to social capital (see Field, 2003 and Putnam, 2000 for further insights), this is the one I will employ. Possessing a sense of place where trust and acceptance exists may bring substantial benefits.

Love and Being 'Close Knit'

The relationships between the LWCs and the other midwives appeared to be central to the development of social capital and integrative power (shared power) and the facilitation of safe and productive care at both Springdale and Northvalley. Whilst the findings suggest that the labour wards were challenging environments in which to practise, they also suggested that the LWCs' *'passion'* (June B82N, Hazel B72N, Liza B71N) and *'love'* (Hazel B72N, Nicola B71N) for the job was significant. All of the LWCs indicated that they were *'committed'* (Donna B72N) to the job, *'loved'* (Valerie B71N) where they worked, were *'proud'* (Hazel B72N) of their achievements, such as the low caesarean section rate and high normal birth rate and even though it was *'draining and tiring'*, had *'job satisfaction'* (Nicola B72N).

Most of the midwives at both Northvalley and Springdale spoke of how they loved the place in which they practised. Boulding (1989) states that love is the most basic and potent form of integrative power. Love, Honneth (1995) suggests, is a primordial form of recognition and respect. Although they were colleagues many of the midwives were friends and some symbolised labour ward as their *second life* (Hazel B72N) or *home*:

I have always said this that after my own family at home. Here is like my second family because I do feel that you know really close relationships and we look out for each other, everybody does really and not just the midwives as well but all the support staff as well, the HCAs[health care assistants].

(Judith B72N)

Judith's statement appeared to suggest a deep seated affection for labour ward. I observed Irene (B71) come close to tears during her interview as she described the close relationships as being *'close knit'* at Springdale and how they *'loved the unit'* [maternity unit]. Tuan (1977, p.137) suggests that 'space is transformed into place as it acquires definition and meaning' and that the 'concept of place as home should give it supreme value' (Tuan 1997, p.153). The use of the word home by the midwives

may be viewed as being symbolic of them delineating their territory within the field and the integrative power derived from the association may have facilitated their ability to practice within it regardless of the difficulties experienced. Florence suggested:

You know, because we're so close knit, we are very close and because a lot of us have worked together a lot of years so I think it, you know, when you get the challenging patient or like challenging situations or scenarios or emergencies. It's knuckle on, and...right, what's happened?

(Florence B71)

The midwives at both Springdale and Northvalley appeared to have developed personal relationships as they socialised outside of work. I observed on both sites midwives *arranging to go on holiday* (Fieldnotes Springdale, 09.03.13) and *evenings out* (Fieldnotes Northvalley, 04.06.13). They also appeared to have intimate experiences in that they facilitated one another's births as Judith (B72N) stated:

Oh right yes now Hazel. I mean, I absolutely love Hazel to bits. She delivered my baby.

The positive interactions that occur between people in a social network may lead to social capital and the existence of dense relationships. Dense relationships relate to the close relationships one may have with family or close friends (Coleman 1988). The strength of the bonds in dense relationships facilitates activity where trustworthiness is assumed and may enhance working practices and teamwork. A tension appeared to exist however, between the LWCs' love for the job and the fatigue and stress it entailed. It appeared that the position of LWC attracted a particular type of person. Several of the LWCs at both Springdale and Northvalley suggests that they thrived on stress:

I mean the work is very challenging, it's very busy, it's very stressful but at the same time I kind of quite thrive on a lot of that I think. I feel like the labour ward is very much my thing, my area.

(Judith B72N)

Jessica (B72N) suggested that the challenging environment was akin to an '*Adrenaline rush*' for her; and Miriam (B71N) appeared to '*get a kick*' from practising in a busy environment and Thelma (B72N) '*enjoyed*' being a clinical leader on the labour ward. Enjoyment in the job appeared to be related to the '*esteem of others*' (Judith B72N), '*being in control*' (Rachel B72N), being a '*good challenge*' (Rose B71N) and the '*responsibility*' (Monica B71N). The LWCs' relationship with the field appeared to be one of both love and hate that may have facilitated resilience and their survival in a difficult role.

There was evidence that the LWCs at both Northvalley and Springdale had been '*doing it [the LWC job] a long time*' (Denise B72) and that many of the midwives were '*born here and have lived here*' (Irene B71). Lesser (2000) suggests that time is important for the development of social capital, as it relies upon the continuity of the social structure. The stability and durability of relationships are associated with high levels of trust and cooperation (Putnam, 1993) which may have enhanced the symbolic power of the LWCs and others' deference to them. The midwives appeared to be interdependent of each other as they relied on one another for support and Lesser (2000) suggests it is in such contexts that high levels of social capital are generally developed.

The interdependence may have arisen as a means of managing the heavy workload, stress and emotion work. Sinek (2014) suggests that love is involved in the type of transaction Florence described above: the midwives worked hard or '*served*' because of feelings rather than instruction. He suggests this may make them '*better*' people as they appear to have a sense of duty (Sinek 2014). This is similar to the power of the Panopticon that required no force to enhance compliance. Sinek (2014) suggests that caring and serving derives from a sense of danger that facilitates people to work in a '*circle of safety*' or '*tribe*' of one's own to survive. The social capital also appeared

to confer symbolic power to the LWCs as it was a means of controlling the work force by facilitating compliance, reducing resistance and increasing productivity.

The close relationships, however, appeared to compromise certain aspects of clinical leadership for some midwives. Rachel, a LWC at Springdale suggested:

If you've got close friends and you need to address an issue with them, that's you know, I think because it's such a close unit, it makes it a little bit more difficult. I mean others might find it easier because they haven't got that relationship but you know, sometimes...

(Rachel B71N)

However Judith (B72N) stated that she was able to manage any difficulties by trying, at work to 'keep everybody the same'. Although there are advantages to close relationships in creating social capital there may also be negative associations. Lesser (2000) suggests that whilst strong ties, such as family and close colleagues share common networks and knowledge they may be less effective at providing new sources of knowledge and therefore change. Leslie, the matron at Springdale concurred:

A lot of the staff here [Springdale], they [LWCs] don't...they've not moved. They've worked here, trained here, worked here and they've not had input from anywhere else and they've [LWCs] got strong views how things should be done.

(Leslie B81)

The close relationships appeared, as will be discussed in chapter seven, to contribute to the midwives being more inward looking. Being close knit appeared to reinforce the exclusive identities of the LWCs homogenous group and to impact upon the agency of other midwives.

'Effective' *Clinical* Leadership Habitus

Sinek (2014) suggests that leadership is not only associated with rank or position and if it was only this, not everyone would follow the leader. The political power associated with delegated positions may require other qualities inherent in the leader's habitus, as the clinical leadership literature also suggests (Christian and Norman, 1998).

Although it appeared that bullying and controlling habitus by some LWC clinical leaders was tolerated and associated in some instances with 'effective' clinical leadership, it was also apparent that other 'softer' habitus of the LWCs' clinical leadership were preferred. Transformational leadership, as discussed earlier in chapter two (p.31), is commensurate with a leader possessing charisma, inspiration, intellectual stimulation, having consideration for others and inspiring their followers (Alimo Metcalfe, 2006). Transformational leadership characteristics were described by the midwives as distinguishing 'effective' clinical leadership and this type of habitus appeared to possess embodied cultural capital and facilitated the development of social capital through enhancing group cohesion, motivation, and facilitating effective care on both labour wards.

Valuing and Empowering Others

If you give respect, you get respect back, and if you are one of these people, "I am the Band 7 [LWC]. You will do as I say", then that is not respect and you are not going to get the best out of people.

This is what Laura (B62N) suggested when she spoke about respect and being respected. The LWCs who were nominated as 'effective' clinical leaders appeared to value those they practised with. They demonstrated this by '*listening to the points of view of other midwives, acknowledging their life experience*' (Gina B72n), by speaking to them in a '*respectful manner*' and treating them '*fairly*' (Liza B72N), and according them some '*status and trusting them to inform her*', should they have any concerns (Valerie B71N). Jessica (B72N) suggested that:

She (the LWC) gave this confidence and reassurance. When somebody trusts you, you can trust yourself and believe they can get through something.
(Jessica B72N)

Those LWCs who were nominated as 'effective' clinical leaders carried out teaching and passing on their clinical skills. They were involved in '*suturing workshops*' and giving '*top tips*' (Sylvia B71N), such as giving advice on facilitating a woman's position

for birth (Hazel B72N) or supporting other midwives to learn new skills, such as *facilitating breech birth* that I observed Gina (B72N) undertake at Northvalley (Fieldnotes, 28.07.13). Although I suggested earlier that managing the safety of the environment and the socialised nature of the LWC may inhibit change the LWCs were at some level engaged in the development of practice. The LWCs shared their clinical skills and knowledge and therefore conferred other midwives with some cultural capital of their own. However, the act of power sharing enhanced the LWCs' own symbolic cultural capital in the field as it was recognised as valuable by others. What appeared to be power-sharing conferred more power on those who were already powerful. Although, I acknowledge that power cannot be given but must be taken, it would appear that teaching and the sharing of clinical knowledge was a prerequisite to the midwives' empowerment. The socialisation of clinical practice through the passing on of skills and knowledge from one generation of midwives to another will be discussed in chapter seven.

Wendy (B52) suggested that the LWCs balanced facilitating the practice of the less experienced midwives with helping them to question their practice which '*keeps you going*' and '*helps you concentrate more on why you're doing what you're doing and why your care looks like it looks*'. The LWCs were perceived as role models whom other midwives aspired to be, Valerie (B71N) suggested that if other midwives observed the LWC facilitating care appropriately, they were more likely to wonder '*if I can do that*'. However, there were also those grumpy and bad tempered LWCs I referred to earlier, who although Judith (B72N) suggested:

...had a lot of experience, I wouldn't necessarily want to be like them.
(Judith B72N)

The effect of enhancing confidence through reassurance and facilitating the development of skills and knowledge is resonant of the midwife-mother relationship, where empowering the mother to trust her own body's ability to give birth may

enhance her confidence and facilitate a normal birthing process (Fahy and Hastie, 2008). The midwife-LWC relationship may need to be the same if midwives are to be empowered to care confidently. June (B82N), the Matron at Northvalley suggested that *'if you look after your team and engender the correct qualities that this will be transferred into the woman and her family's experience'*. The facilitation of effective care is the main objective of what I believe clinical leadership to be. However who was responsible for deciding what the 'correct qualities' were was not clear.

'Selling the Passion' and 'General Reciprocity'

Most of the LWCs at both Springdale and Northvalley appeared to motivate the midwives that practised alongside them. Liza (B71N) suggested that:

You would hope that you [the LWC] would sell the passion for what is a good job to have really.

(Liza B71N)

The effect of the LWC being motivational meant that midwives were inspired *'to do a good job for them'* [the LWCs] (Irene B71) and therefore appeared to enhance productivity and the quality of the work. The LWCs motivated other midwives by taking care of their physical needs, such as ensuring that they had a break during their shift. The LWCs' responsibility appeared selfless as they *'always had their lunch last'* (Amy B62, Yvonne B72, Valerie B71N). Sinek (2014) suggests that the title of leader is aligned to those people who go first, take risks and sacrifice for others. However Denise (B72) suggested that one of the reasons she ate last was so that she was able to have her lunch alone and not be disturbed and may be perceived as an act of self-preservation rather an act of kindness or care. Caring for the midwives on each shift was considered to be a strategy that helped them *'get through the busyness'* (Jessica B72N).

The symbolic social power inherent in the LWCs' motivational habitus appeared to be a resource that was invested in the anticipation of a future return for the

investment. Putnam (2000, p.135) refers to this phenomenon as 'the norms of general reciprocity', in that 'if I do this for you now, you will return the favour at a later date'. General reciprocity appeared to exist between the LWCs and the midwives that appeared to facilitate productivity and also team work. Hazel (B72N) suggested '*if you are nice to them [other midwives] then they will pay you back*'. Hazel was 'nice' to the other midwives in that:

If I can say "sit down and get a drink" or you know... "Get a rest" or if they [the midwives] have had a bad shift the night before with a slogger [woman having a long complicated labour], I try to say "well I won't give you a slogger tonight."

(Hazel B72N)

Being 'nice' was reciprocated by hard work (Jessica B72N, Hazel B72N, Valerie B71N, Karen B71N) in that the midwives accepted the practice of caring for either multiple women or one woman after the next without rest.

The midwives who helped each other out appeared to have informal contracts of behaviour and suggested that teamwork was valued. Team working was compared to camaraderie that is suggestive of working against the enemy (the workload in this instance) in unison. Karen (B71N) stated that the midwives referred to one another as 'comrades' because *even 'in like the thick of an awful shift, you still like to keep, you know, going'*. Teamwork appeared to facilitate the ability of the midwives to be available to care for the next woman to be admitted. It kept the process of caring for one woman after another running and appeared to elevate the morale. Lora suggested:

Most of the time it's lots of team work. I find it goes both ways. Like, I offer a lot of support and help and I find that people do the same for me. It's really appreciated when they do. Like, when you've had a delivery, so, notes, someone will do [weigh and examine] your baby, just anything... [ask] "Do you want a drink for that lady?" "I'll get your stickers". "Do you want a Syntocinon drip?... and everybody does that.

(Lora B61)

On both sites I observed midwives helping each other with their work:

When one midwife was going for a break someone asked her to check some drugs for her. However one of the LWCs offered to do this whilst she had a break.

(Fieldnotes Springdale, 09.03.13).

The midwives helped each other by: *cleaning rooms, completing notes, examining babies, finding information about women who had been admitted with regard to child protection issues* (Fieldnotes Springdale, 04.06.2013, 30.09.13 and Northvalley, 06.06.13). *One of the junior midwives was going out to eat and they were helping her so she would not be late off duty and a LWC on night duty prevented a junior midwife from being off late by completing the computerised record* (Fieldnotes Springdale, 30.09.13). I did not observe midwives refusing or arguing about the work they were delegated by the LWC, the midwives on both sites appeared to accept their allotted work. Consideration was given to the emotional well-being of midwife at Northvalley who had been caring for a woman whose baby had died over the past couple of days. *She was asked if she was able to continue caring for the woman that day* (Fieldnotes Northvalley, 06.06.13). When help was required on both sites midwives *did not appear to hesitate to jump up and help each other* (Fieldnotes Springdale, 04.06.2013, 30.09.13 and Northvalley, 06.06.13). The social capital inherent in the team work and camaraderie appeared to grease the wheels of production which is consistent with the historic mechanistic production line associated with labour wards: it gave the LWC symbolic cultural capital to develop the power to determine the way practice was performed.

Clinical leadership has been associated with innovation, having a vision and the facilitation of change. However, at both Northvalley and Springdale the LWCs' leadership appeared to be overwhelmed by getting the midwives through the day and facilitating safety: they coordinated the field rather than being able to change it. Whilst the LWCs nominated as 'good' clinical leaders possessed transformational leadership qualities, having a vision, perceived to be a characteristic of

transformational leadership, was not something that was attributed to them. As in Stanley's (2006, 2014) studies values rather than vision appear to be more important. The LWCs were congruent, rather than transformational clinical leaders.

The LWCs appeared to impact upon the labour ward atmosphere. Those LWCs who came to work in a bad mood were perceived as having a negative impact on each shift. Hayley (B61) suggested that:

You come in the morning and you see who you're on with and your heart sinks and you think, oh God it's going to be twelve hours of torture this. ...and you shouldn't have to feel like that...just depending on one person.

Judith (B72N) suggested that she attempted to keep the atmosphere on labour ward 'nice' even when it was 'horrendous' or 'stressful' by trying to 'jig people along' by being *responsive to them [other midwives] if they do seem to be 'struggling' or 'upset'*.

This finding is similar to the aesthetic qualities observed in the clinical leaders in Ennis et al's. (2013) study that enabled them to create a positive atmosphere. Creating a happy working environment was something those LWCs nominated clinical leaders managed to achieve and appeared to be instrumental in whether the midwives enjoyed their work or not. Liza (B71N) suggested that practising as a midwife on labour ward was 'tough' and that this meant that it was therefore important that the midwives enjoyed their work. Keeping the atmosphere 'light and airy' was associated with the LWC clinical leader having a 'sense of humour' (Hazel B72N, Karen B71N, Judith B72N), that it facilitated practice, 'makes people go that extra mile', 'gets the job done' (Karen B71N); *relieves stress* (Miriam B71N) and appeared to maintain a 'positive and happy mood' (Liza B71N). I observed on both sites, although more often at Springdale (the responsibility for the difference appeared to be that the midwives did not tend to socialise in the office at Northvalley as they did at Springdale as they used the staff rest room more, that the radio was usually playing in the background in the office and the midwives were often *singing* and occasionally *dancing* (Fieldnotes Springdale, 21.02.13, 12.03.13, 30.09.13, 04.10.13 and Northvalley,

14.09.13). Valerie (B71N) suggested that creating a positive environment was a means of '*propping the team up emotionally*' which appeared to resonate with the emotion work involved in the LWCs maintenance of a 'game face' I explored earlier in the chapter. However, when I asked the LWCs where they looked for their own support most suggested that they found this '*amongst themselves*' (Sylvia B71N), rather than the managers, whom I have suggested in chapter five appeared to be removed from practice and therefore unavailable. The lack of support appeared to place the LWCs in a vulnerable position both emotionally and clinically but may be why the LWCs on both labour wards, who relied upon support from one another, became a formidable group.

Summary

Part two of this chapter examined the ways in which the habitus and capital of the LWC clinical leader structured the field. The LWCs' clinical leadership practice and their followership was a social process, as relationships in the field mattered. Being 'close knit' and love for the field appeared to develop social capital that facilitated practice in the stressful field as well as creating a sense of duty. However, friendships made it difficult to address concerns regarding practice and had the potential to result in hegemonic and insular practices. Teamwork and general reciprocity were central features of the social capital created by the relationships in the field: they enhanced the LWCs' symbolic power, made midwives more accepting of their workload, which may have reduced their own social capital, but were necessary to facilitate the smooth running of the field. The LWCs' clinical leadership was concerned with productivity and safety, rather than innovation and change for which leadership is usually associated.

It was suggested in part one of the chapter that the LWC possessed symbolic cultural capital through her ability to maintain the safety of the field through her control and

strength. However other, transformational leadership characteristics were associated with 'effective' clinical leadership habitus. Valuing others, teaching, sharing skills and being motivational appeared to enhance the symbolic power of the LWC. However, these characteristics also built the foundations for the empowerment of the other midwives in the field. Whilst it was evident that not all LWCs possessed transformational leadership qualities, those who did appeared to mirror the midwife-mother relationship with their colleagues. Transformational leadership may be important to midwifery as it has the potential to enhance well-being, job satisfaction, effort and productivity that may indirectly enhance the quality of direct care and it reflects what I perceive clinical leadership to be. However, possessing a vision, one of the inherent characteristics of a transformational leader was not recognised of the LWCs: they appeared to be congruent rather than transformational leaders. The caring habitus and advocacy demonstrated by those LWCs perceived to be 'effective' fostered a sense of duty, compliance and may have reduced resistance to her leadership. The creation of a 'happy' labour ward represented an emotional prop for the midwives in the field. However, the LWCs did not have access to similar emotional props and therefore found support in one another which may have made them a formidable but vulnerable group. Chapter seven will explore the identity of the LWCs, their impact on others and the struggle to re-establish their identity in a field in flux.

CHAPTER SEVEN: IDENTITY; HABITUS AND CAPITAL

‘The struggle for recognition is a central part of social life.’
(May & Powell, 2008, p.126).

Introduction

This final findings chapter will explore ‘identity’, the second of the two central themes that emerged from the data in relation to Bourdieu’s Theory of Practice. The socialised nature of the LWCs’ clinical leadership habitus will be explored and the impact of their symbolic cultural capital on the agency and autonomy of other midwives, and upon the field will be examined. The chapter will also examine the struggle for recognition and symbolic power within a field in flux as well as the strategies the LWCs employed to protect both their professional habitus and capital.

The LWC: Developing Habitus and Capital

Socialised Habitus

Whilst chapter six suggested that the social relationships at both Northvalley and Springdale contributed positively to midwifery practice in the field, it was also apparent that the development of the LWC habitus was socialised, in that it was learned through observing others and adopting their behaviour. Whilst the socialised nature of the LWCs’ habitus enhanced their symbolic cultural capital, it simultaneously discouraged change and dissent and assured conformity.

‘Learning on the Job’ and ‘Working to the Same Level’

Bourdieu conceived of habitus as being a way of theorising a self that is socially produced (Lawler, 2004) and therefore acknowledged the importance of social relationships in the development of habitus. The LWC habitus appeared to have been passed from one generation of LWCs to the next. The LWCs learned their behaviour from the midwives with whom they had previously practiced. Beverley (B72N)

suggested that she had learned how to be a LWC ‘*on the job*’ and Alexis (B71N) had been influenced by her ‘*leaders*’ who had been ‘*good examples [of LWCs]*’ she had, ‘*taken bits [behaviours] from*’. The LWCs perceived they were role models as other midwives ‘*looked up to them*’ (Ellen B71) and the LWC led by example, ensuring that ‘*they [other midwives] did not cut corners and maintained standards*’ (Karen B72N). Learning from the LWC appeared to be as a result of the symbolic cultural capital that their position represented in the field.

Midwives learned their clinical skills from ‘*working with the experienced staff*’ (Beverley B72N) and Kimberley (B72N) suggested; *they [LWCs] ‘made me what I am today*’. The scary LWC habitus also appeared to have been learned. Hazel (B72N) spoke about a midwife who had recently retired but had been admired:

Everybody used to be sort of frightened of her but [she] was excellent and that’s what you want in the end, the excellent midwife and I always used to think I’ll be like that.

(Hazel B72N)

Being scary was something that was assimilated: had become a feature of the LWC over time and was associated with successful LWC habitus. However Lawler (2004) suggests Bourdieu conceived that habitus was not determined but generative and may only make sense in particular contexts and time. The scary behaviour of the LWC in the past may not be an acceptable facet required of clinical leadership today, even though it appeared to be admired. Alexis’ (B71N) experience of practising with others also facilitated her ability to recognise the midwives she did not want to emulate when she stated ‘*you think ...I don’t want to be like her*’, that suggested adopting behaviour was neither prescribed nor forced.

Formal development of the LWCs’ clinical leadership did not appear to be common place. However, Valerie (B71N) and Donna (B72N) spoke about attending a Leading an Empowered Organisation (LEO) course. Valerie (B71N) suggested that this course developed her in *a little way*. Although it was not clear what Valerie (B72N)

meant by 'little' she did not appear to enjoy the course and felt that most of her development came via her '*clinical experience*' and '*being a mother*'. The lack of formal leadership and learning on the job echoes the literature that suggests a lack of preparedness for leadership and being reliant on local clinicians for learning may prevent change and lead to insularity (Martin & Waring, 2012).

The leadership development that I observed was the 'Wing Man' position that I referred to in chapter five, where more experienced Band 6 Midwives supported the LWC, and the 'acting up' as a LWC position that was also available to them. At Springdale I observed a Band 6 midwife who was 'acting up' and in charge of the shift being coached to alter her decision making in line with that of the LWC:

She had earlier agreed to let one of the HCAs [Health Care Assistant] accompany a midwife on the transfer to another hospital of a woman with a preterm pregnancy and had been questioned by one of the Band 7 Midwives (LWCs) on duty about this decision. She was asked "what would Valerie say?"
(Fieldnotes Springdale, 09.03.13)

Many of the LWCs at Springdale and several at Northavalley were near to retirement age and had practised as LWCs for several years. Miriam (B71N) suggested that these LWCs were '*not accepting of change*'. Ellen (B71), the longest serving LWC at Springdale, perceived socialisation to be positive when she stated that socialised learning meant that other LWCs would '*carry on from where they left off*', gave the midwives '*ownership*' of the labour ward and ensured that '*everyone worked at the same level [in the same way]*'. Mander and Murphy Lawless (2013) suggest that practising in particular ways may enhance feelings of security in the context of a chaotic environment. The LWCs' clinical leadership may have been borne out of the unsafe field within which these midwives practised. However, it appeared to lead to outdated practices being accepted and remaining unchallenged, such as, asking women to '*wear theatre gowns [rather than the woman's own clothes] prior to epidural analgesia*' and '*routinely breaking the water around the baby*' that were described by Miriam (B71N) as happening at Springdale.

Giddens (1989) suggests that professional socialisation is present in all cultures and commences inside a family unit, (that the midwives on both labour wards appeared to have created), through which the practices and beliefs are shared and adopted. Grenfell (2007) stated that Bourdieu perceived that habitus is first significantly shaped in the family. As many of the midwives on both labour wards conceived their places of work as home and their colleagues as family their socialisation there may have been as significant and deeply ingrained. The socialisation of habitus involves the naturalisation of the doxa or unwritten rules of the game over time that become symbolic, as it not recognised as such, and therefore powerful within a culture (Grenfell, 2007). Bourdieu suggests that socialisation is not always a conscious activity, however, and cultural norms and habitus may be unconsciously learned (Elliott, 2004). The socialised nature of learning from one generation to another perpetuated a particular way to do things and restricted other midwives from facilitating change. This symbolic form of clinical leadership did not appear to reflect the liberal, change-facilitating, clinical leadership that is espoused in the literature (The King's Fund, 2011, 2012, 2013, 2014a, 2014b, 2015, NHS England, 2014). Education and training for future clinical leaders in midwifery may therefore be implicated.

Followers' Habitus and Capital: Agency, Accountability and Autonomy

The obedience and conformity that occur during socialisation and the symbolic cultural capital within an institution that creates the expectation that rules are obeyed may result in a loss of autonomy, the ability to reflect and little authority to question practice (Parsons & Griffiths, 2007). Professional socialisation can therefore undermine professional practice. In chapter six (p.172) it was suggested that there were perceived benefits to the LWCs having some power over the midwives.

However, the habitus and symbolic cultural power that the LWCs possessed appeared to impact upon the agency of the other midwives.

Agency

The Way we do Things Round Here and 'Fitting in'

The adherence to practising in a particular manner existed at Springdale. Miriam (B71N) who was a LWC in a temporary 'acting' capacity and nominated as an 'effective' clinical leader stated the LWCs practiced in a particular way '*because they've always done it*' and it was '*very difficult to change things*'. Hayley (B61) suggested the guidelines were '*their (the LWCs) way, the [Springdale] way or no way*'. Rachel (B71N) stated that Springdale would, '*see a big difference when a big group of people retire*' which suggested those LWCs who were due to retire held a significant amount of symbolic cultural capital that could not be contested and that other midwives were powerless to change the practice doxa until this group were no longer practising. However, Swartz (2013, p.119) suggests whilst clinicians may 'outwardly adapt to the prevailing social perceptions', they are able to practice 'inwardly to undermine the dominant conceptual and social order in small and sometimes large ways'. Swartz's (2013) suggestion is similar to the concept of 'doing good by stealth' (Kirkham, 1999 p.734, Begley, 2002, Stapleton, Kirkham, Thomas & Curtis, 2002, Pollard, 2005) referred to earlier in chapter two (p.41) that is a feature of subordinated groups.

The clinical practice at Springdale was valued and other clinicians appeared to have to 'fit in' with it. Karen (B71N) suggested that midwives or doctors had '*to fit in*' to Springdale's ways and Rachel (B71N) stated that it took the doctors '*a while to accept that's how it works here*'. The ability to control the behaviour of the medical staff reflects the LWCs' symbolic cultural power in the field and contradicts the natural hierarchy in the NHS which places doctors above nurses and midwives. At Northvalley the LWCs control and cultural capital did not appear as powerful and may

be explained by the high risk environment and the usual presence of obstetricians and anaesthetists that may have tipped the balance of power in the doctors favour. However, Frances (B62) spoke about one of the LWCs who contradicted the plans of care she facilitated for women. *Frances stated:*

You've thought of a plan of care for this lady and you know that they're [LWC] going to say a different plan of care every time.

(Frances B62)

Amanda (B62) also suggested that, '*they [LWCs] want to tell us how to manage our women*'. The implication was that the LWC influenced the way in which midwifery care was practised by virtue of their symbolic cultural capital. A few of the more experienced Band 6 Midwives at Springdale and Northvalley did not all appreciate the LWC interfering with their care:

Band 6's hate it that the Band 7 [LWC] will come in their room [and say], "What's happening? What's going on?" Or question you when you go out of the room and some Band 6's hate it. They'll say, "That's my woman and I should be able to look after her until there's a problem" But I don't. They [Band 6 midwives] say "It's my woman and I can look after [her] and I'll only ask when I need a hand". Whereas, I think I feel reassured that there's back up there, not that I want them to do anything, just that they're [LWCs] aware of what's going on.

(Hayley B61)

Frances (B62) suggested practising on labour ward was '*regimented*' and it may '*stifle your practice. You start to become less autonomous about the way that you practise and you fall into a kind of a little regimented midwife*'. The use of the word '*regimented*' implies, having a military approach to care, a non-thinking midwife: a follower of orders. The LWCs appeared to possess symbolic cultural power that commanded compliance. Bourdieu, according to Swartz (2013, p.108) suggests that when a person becomes part of a group they '*dispossess themselves in favour of a spokesman*'. However, the spokesperson may not always represent the views of everyone. Foucault (1979) also suggests disciplinary power is invisible and requires the cooperation of the subject. Foucault (1991, p.136) suggests that discipline produces subjected, obedient and practised '*docile*' bodies so that others may

operate as they wish. However, there was some evidence that the midwives were able to practice how they wanted to. Selma (B51) suggested she had the option to defer to others to support her:

If they [LWCs] disagree, there is usually more than one Band 7 [LWC] on the shift so I would go and ask what the other one thought, if they still disagreed I suppose I could get the doctor involved if it was appropriate or a supervisor if I felt that strongly about this. But it's never happened.

(Selma B51)

Resistance to the control of the LWC was apparent, although a struggle, when Frances (B62N) described a strategy that she employed if she disagreed with the LWCs advice with regard to the woman she was caring for:

I would get them [LWC] to write in their [the woman's] notes to say ...well if you want her to stay, you can talk to her [the woman] and you can say that is your plan of care, because it's not my plan of care really. I've done that a couple of times. It's still a battle, you know, that's the same battle you're going to get ...every time. It doesn't make it any easier (laughs).

(Frances B62)

Miriam (B71N) was acting up as a LWC and was keen to come forward with ideas and suggest changes, however, the LWCs appeared resistant to her:

I suggested, "Why don't we just paint the walls different colours then? [the LWCs said] "...because it has to be magnolia this hospital. That's what happens here. It has to be magnolia". So I've stopped now but I think that's what worries me. I'll stop having ideas. I'll stop...I'll just start thinking I'd better not say that because everything you say, they say no, and then when people say no, they make you feel stupid for asking it. They make you feel stupid for even suggesting it don't they? But then you think yeah, they're probably right that is a daft idea, so then next time you question whether you should voice your ideas.

(Miriam B71N)

Freire (1993) suggests it may be difficult for the oppressed to have control of their destiny or intervene in practice if they belong to a culture of silence. Swartz (2013) recounts that Bourdieu's suggestion that leadership, which in essence is delegated authority, deprives followers of an effective voice. He suggests professional socialisation may be a means of being accepted as a member of a group and not taking on the group's socialised habitus or doxa may result in remaining outside of it

(Swartz 2013). Challenging the doxa caused Miriam (B71N) to perceive she was a 'trouble causer' and a 'rebel'. May and Powell (2008) suggest that:

'What is at stake is the conservation or subversion of the structure of the capital within the field. Those who are inclined towards conserving its power relations are defined as being engaged in orthodoxy, while newcomers to the field are likely to be subversive and engage in strategies of heresy.'

(May & Powell, 2008, p.132)

Miriam (B71N) appeared concerned about her rebelliousness as she had moved to Springdale with the 'hope of being promoted' to a more senior position and it may have compromised her ability to realise this. Although Miriam (B71N) appeared to acquiesce because of her desire for promotion, in Hayley's (B61) case her acquiescence may have been to avoid the sanction of not 'fitting in' and related to being junior, new to the hospital and emotionally vulnerable at the time. Hayley artificially ruptured the membranes (ARM) of a woman against her own judgement. The LWC told her that she had to:

"ARM her. That's what you should do. She's an induction and you have to ARM her" and I went and did it and drove home and thought, why did I do that? Normally I wouldn't have done and after I did it, I thought...oh, I shouldn't have done that.

(Hayley B61)

Miriam (B71N) also found herself calling for a paediatrician for most births that she had not done in her previous post:

But I have got used to it now...you see. Two years that's all and I'm used to it. I've started doing it, ringing the paed[s] [paediatricians] because I think I'm scared. I've started thinking now...ooh I'll get into trouble if I don't get one [a paediatrician].

(Miriam B71N)

Although it is acknowledged that all persons have the ability to act unless under physical restraint (Giddens, 1989), it appeared that the symbolic power of LWC habitus and of the cultural norms were sufficient to coerce Miriam (B71N) and Hayley (B61) to conform and practice in ways contrary to their beliefs. It was clear that Miriam was recognised (and therefore possessed some cultural capital in the field) by her

appointment as an 'acting' LWC and had been nominated by one of the junior midwives as an effective LWC, and therefore accepted into the group, however, it appeared that being able to continue in the position she had to toe the line. Freire (1993) suggests that those who are dominated adopt the image of the oppressor and their rules, and therefore oppression is domesticating. However, Swartz (2013, p.55) suggests Bourdieu conceived of the acceptance of the rules of the field in this manner as 'unauthentic thinking', in that the self-deception acts as taking part in the field for some benefit. Bourdieu generalised Max Weber who he cites (1990, p.76) by suggesting that people obey rules when they have greater interest invested in obeying the rule than not: Bourdieu (1984, p.122) suggests that submission may be liberating, as it may cast off what makes us different and that people may act in a manner that is not 'progressive' as they are not 'fools': they are aware what may be in their best interest in the field. The midwives' acceptance of the rules of the game on labour ward cannot be perceived as symbolic violence as they did not accept the way things were without question, they lacked the cultural capital and power to affect change. Miriam (B71N) and Hayley (B61), however, compromised their professional principles and values.

Midwives who spoke of their resistance, however, were in the minority which may suggest that others were either afraid to speak out or symbolic violence was in operation through their unconscious acceptance of the symbolic power in the field.

Tourish (2014) adds:

'For followers, the decision not to offer critical feedback is a demonstration of agency manifest in silence, based on an often justified calculation of self-interest.'

(Tourish, 2014, p.85)

Tourish's (2014) statement may be true of newly qualified midwives who may perceive they do not have sufficient experience to contradict what other, more senior

clinicians suggest. Midwives new to the hospital trust or those seeking promotion may want to fit in and be accepted. It also suggests that the mother or baby may not be central to the care given as decision making was tied up with pleasing the LWC.

It appeared that dissent or resistance to the cultural norms on labour ward was not encouraged. Tourish (2014) suggests that the symbolic capital attributed to organisational consensus that perceives the dissent of non-leaders as resistance, that should be overcome, rather than useful feedback, is misplaced. He suggests that dissent may be healthy and productive, through engaging with differing ideas and opinions and that constraint on dissent may prevent learning when mistakes are made (Tourish 2014). The continued emphasis on unrestrained leadership agency may produce a rise in 'imaginary Gods' who do not meet the needs and expectations of their followers (Tourish, 2014, p.93). Interestingly, whilst observing at Springdale (Fieldnotes Springdale, 01.03.13), one of the midwives recounted an incident that suggested the clinical leaders may be perceived as having '*divine*' authority. The drug cupboard keys had been lost and she referred to them as the '*God Keys*' in that they were the responsibility of the LWC on the shift. This resonates with what Donna (B72N) at Northvalley suggested with regard to her transition to the LWC role; the effect of the responsibility of being a LWC and the desire to get things right:

I have panicked about things that I'd get [situations she encountered] as a Band 6 that I would just have done in the logical pathway and processes but as a Band 7 [LWC] you start to examine everything because you have to be right and you just over examine things because you don't want to get it wrong.
(Donna B72N)

It could be suggested that being good enough was not an option for the LWCs. However, Samuels (2001) suggests that when considering leadership one should apply the concept of 'good enoughness' of which failure is a core element. 'Good enoughness' is an idea originally related to the idea of the good enough mother or parent, in that the notion of the perfect parent is unrealistic and may foster dependence. Samuels (2001, p.79) suggests:

‘Good enoughness is suggestive of ways of coping with political disappointments without excessive dependence on a tyrannical leader on the one hand or exasperated and disgusted withdrawal from the political process on the other. If our goal is perfection, we are doomed to subside into despair and depression; we feel impotent and cannot act. If we only see how awful everything is, we are tempted to wash our hands of politics and let others (leaders) deal with things; we are paralysed and, again, lose our sense of agency.’

(Samuels, 2001, p.79)

‘Good enoughness’ may be relevant to the problem of agency and leadership. Having a good enough LWC may mean that non-leaders do not become dependent upon them to solve all their problems and so they themselves are able to learn how to manage. However, the ability of the non-leader to be able to dissent and contribute may be dependent upon the relinquishing of symbolic cultural capital and the sharing of responsibility and power by the clinical leader.

Autonomy and Accountability: Having a ‘Go To’ Person and ‘Spreading Responsibility’

The practice of reporting back to the LWC on both labour wards did not appear to foster the autonomy of the other midwives and required obedience. The Consultant Midwife Jacqueline (B82) at Northvalley suggested that by having a LWC, who ‘*has to be asked about everything and gives the nod [has to agree] about everything*’, may not facilitate autonomous practice. The LWCs were the ‘go to person’ (Amy B62) to whom midwives reported back with regard to the progress in labour that had been made or to the condition of the mother and fetus/baby’s condition. Some of the reasons given for contacting the clinical leader were highlighted by Anita:

If the woman hasn't been making progress [in labour] or if her contractions have slowed down I would keep her [the LWC] informed. If I've had a baby and worried about a tear [of the perineum], or if we need sutures [stitches] I would get a Band 7 [LWC] to come in and have a look at it... Yeah if I wasn't confident about something and I would always keep them up-dated but if I needed some advice, then yeah I would go to them as well.

(Anita B51)

The symbolic cultural capital of the LWCs was embedded in their habitus as a clinical leader, a source of identity, to which the other midwives subscribed. The midwives practising on both labour wards appeared to accept that they updated the LWC and I observed midwives reporting back to the clinical leader on both sites on several occasions for various reasons, such as:

The Band 5 and Band 7 Midwife discussed removing an electronic fetal monitor to facilitate a woman's mobility.

(Fieldnotes Springdale, 21.02.13)

A midwife came into the office during this time to report on a baby that had been born who had been diagnosed with Down's Syndrome.

(Fieldnotes Northvalley, 12.04.13)

Rather than autonomous, the midwives were heteronomous as they recognised that their behaviours had to be performed in a certain way and acted accordingly. Steiner and Stewart (2009) suggest that:

'Heteronomy for an agent consists of producing a behaviour by notably abiding by the norms that are to a large extent independent of the agent.'

(Steiner & Stewart, 2009, p.529)

The LWC was recognised as possessing the right to direct others and therefore had symbolic cultural capital. The power this conferred was demonstrated by their ability to influence others. Power can only be given by those over whom it is exercised and therefore the midwives appeared to be complicit in their obedience. However, the LWCs also appeared to facilitate the learning of other midwives, rather than being prescriptive. I observed midwives being *asked about their plan of care for the woman that they were caring for rather than being told what to do* at both Northvalley and Springdale (Fieldnotes Springdale, 12.02.13 and Northvalley, 02.04.13). The less experienced midwives were also able to discuss their decision making by consulting the LWC prior to finalising it:

So sometimes, you can be autonomous with what you're doing with a high risk woman but you have to be autonomous and let your co-ordinator know

what you are doing (Laughs). Which seems to be like a complete contradiction doesn't it? You are autonomously saying, "This is what I am going to do. Are you okay with it?" But it doesn't mean you [the LWC] are making that decision for that woman ...to say, "This is what is happening with her. This is what I would like to do". A lot of the time you're saying [to the midwives], "No that's fine. It's excellent." (Beverley B72N)

Rachel (B71N) agreed that as a clinical leader she perceived the need to be able to 'trust' other midwives opinions as they:

... are the ones who have been in that room [caring for a woman] for ten hours. They've had a lot of time with that woman and you see things differently when you spend a lot of time with them [the women]. (Rachel B71N)

There appeared to be some danger inherent in the leader making decisions with regard to the care of women without taking into account of the opinion of the midwife, as Rachel suggested above. Tourish (2014) suggests that networks of interaction are liable to engage in more effective decision making when followers opinions or 'dissent' are incorporated into leadership practice. However, although the LWCs appeared to facilitate decision making, should there be any discrepancy the LWC's decision appeared to be the one that prevailed. Donna (B72N) suggested that the reason why she felt she had to override other midwives' decisions was because as I discussed in chapter five (p.139), ultimately the 'buck stopped' with her. Agency appeared to rest on the whole, with the LWC and her symbolic cultural capital is ultimately what generated obedience and submissiveness in others. However, it may be sensible that the clinician with the most clinical experience and knowledge holds this power should it be required.

The active endorsement by the Band 5 and some inexperienced Band 6 midwives of being overseen and supported in their decision making, as well as being manifest of the symbolic power of the normative practices on labour ward, that drove the way things were done, also appeared to be a result of their inexperience. A midwife at the point of registration (which occurs at the end of her/his three years of education) is

perceived to be an autonomous practitioner, in that she/he is capable of caring for a woman having a normal pregnancy, labour and birth (NMC, 2012). However, she/he may not have the skills and expertise to care confidently for women at high risk of complications in their pregnancy and birth. Practising as a newly qualified Band 5 midwife on the labour ward where high risk women are advised to have their babies may be challenging and require support.

The newly qualified and less experienced midwives appeared to *rely on the LWCs* (Adele B51) more than the experienced midwives for *their support*. The transition from being a third year student midwife who has a mentor for support who is available for consultation, to the status of practising as a midwife, left some midwives feeling more reliant on the labour ward coordinator (LWC) and other senior colleagues for *'support'* and *'reassurance'* for their decision making (Wendy B52). The newly qualified midwives on both sites perceived themselves as having little experience of making decisions with regard to practising as a midwife on labour ward and found it challenging. They spoke about being *'scared'* (Emily B52), labour ward being *'nerve wracking'* (Harriett B51) and, that it was *'nice to be directed'* (Anita B51). Frost (2010, p.158) states that Thomas Hobbes¹² suggests:

'Fear compels us to see the wisdom of leaving the uncertainties and violence of the natural condition by setting up a sovereign to rule over us.'

Frances (B62) also stated:

I think it's quite nice having that cushion and I think it's quite scary over here [labour ward] now, having that ultimate ... autonomy. Because you learn about it in University, don't you... autonomy for women, and your clinical care, but it very rarely goes that way cos there's something always guiding you...and it's scary. You practise defensively if something's gone a little bit wrong, so it's nice to have that coordinator [LWC] there and to have them ultimately responsible for that plan of care for that woman.

(Frances B62)

¹² Thomas Hobbes was an English philosopher (1588-1679) known for his political thought.

Having the 'cover' of the LWC as I suggested in chapter six (p.168), may reassure midwives. However, Bousanquet (2002) also suggests that some persons may prefer to waive self-reflection, accountability and autonomy in favour of a more comfortable, stress-free field. It appeared that agency and autonomy on both sites was a matter for leadership as some of the midwives were afraid. It appeared to be in the best interest of the less experienced midwives to work within the rules/doxa of labour ward as it appeared to keep them safe. Hollins Martin and Bull (2008, p.506) suggest there is a 'conflict between espoused autonomy and the demand for obedience in the hospital hierarchy' and as I have suggested previously, the concept of leadership itself places the agency in the hands of the leader (Tourish, 2014). However the drive to promote clinical leadership in the UK NHS appears to be concerned with distributing power and decision-making which appears to be at odds with this.

Some of the LWCs appeared to be aware that other midwives in the field deferred responsibility to them and that it was becoming '*more common*' (Alexis B71N). Whilst Frances (B62N) wrote the name of the LWC in the woman's notes as an act of resistance to facilitate her ability to practice with some independence, some of the less experienced midwives appeared to do this to defer some responsibility. Nicola (B71N) described this as '*spreading responsibility*'. She spoke about how midwives sometimes wrote her name in the woman's notes that they were caring for as a means of doing this:

I do feel responsible on the shift that I'm working because you know, I mean, you only have to look at people's notes and read them. Well Nicola is in the room, you know? People like to sort of try to, like (laughs) spread their responsibility, you know. So, I am very aware, you know if there are any problems, even if I haven't got direct involvement in it as a coordinator [LWC] I should be aware of what's happening so I will have some responsibility anywhere along the line...and I recognise that and that's probably one reason why I do like to know what's happening.

(Nicola B71N)

Alexis (B71N) suggested that the practice of confirming the LWCs' involvement in a woman's care was '*fine*' and stated; '*we do write in the notes when we have actually*

been in to see the woman. Marion (B51N) suggested that *'if the LWC wrote in the woman's notes that they [LWC] are partly responsible'*. However Irene (B71) suggested that the midwives *use you [LWC] as, a scapegoat, as 'a back-up in case something goes wrong'* (Irene B71). Fahy (2008) suggests that one of the reasons midwives behave submissively, is to hand over decision making to the more powerful person in an attempt to reduce their anxiety of being accountable. Although Fahy (2008) was referring to the midwife's relationship with doctors it appears to have some resonance with the midwives relationship with the LWC as a person who possessed more cultural capital than themselves in the field.

Maternity services and particularly labour wards are perceived to be high risk environments due to the potentially serious outcomes that may occur, such as the death of a mother or a baby when something goes wrong. Mackenzie Bryers and van Teijlingen (2010) suggest that it can be argued that the fear associated with danger may be based on the perception that we are accountable for the risks associated with the danger. The 'spreading of responsibility' and the associated fear of accountability suggest an affiliation with the dominant medical discourse that perceives birth to be risky. The midwives' practice resonates with Hunt and Symonds (1995) and Kirkham (1999) who found that midwives practising on labour wards adopted the dominant medical discourse, rather than their own midwifery discourse as they were oppressed by it and that by doing so the midwives capital in the field was enhanced. Whilst the findings of this thesis concur to some extent with these authors, it appeared that fear and risk were also implicated in their actions. Rather than the midwives' capital being enhanced by its affiliation with the dominant discourse, as we will see later in the chapter, the capital associated with the midwifery discourse appeared to be reduced or over-shadowed. The irony appears to be that the concern regarding danger and risk in birth was occurring at a time when it has never been safer to have a child (Walsh, 2004).

Habitus, Capital and the Field in Flux

Bourdieu and Wacquant (1992) suggest that whilst habitus is durable it is not eternal and is therefore in flux. The LWCs at Northvalley and Springdale appeared to be engaged in a struggle in a changing field, where in an attempt to secure their cultural capital and professional habitus they became guardians of the field.

The Changing Field

It has already been established that the field in which the midwives practised, at both Springdale and Northvalley had become more, high risk. The high risk nature of the field at Northvalley became more noticeable following the opening of the alongside birth centre. The default for women at low risk of complication was to have their babies on the birth centre and therefore labour ward comprised of only those women who were high risk of complication. The move to labour ward being a place where midwifery practice was to care for mainly high risk women appeared to have changed the balance of power in favour of the obstetrician. Although labour wards have always been associated with obstetric care, at both Springdale and Northvalley labour ward territory was previously designated as midwifery, where obstetricians were invited or called when needed. However, this appeared to have shifted, particularly at Northvalley. Gina (B72N) suggested that:

They [the doctors] think it's [labour ward] theirs now.

The professional habitus and cultural capital of the LWCs at both sites appeared to be challenged by the changes in the high risk status of the field. The challenges influenced the LWCs to employ particular strategies to retain their professional habitus as midwives and their symbolic capital and power within the field. Bourdieu (1993) suggests the field consists of power relationships and in times of struggle capital is mobilised. Those professionals engaged in practices that are associated

with the orthodoxy of the field hold the most power (Swartz, 2013). The orthodox defend the existing order and those at the opposite try to accumulate orthodoxy.

Misrecognition and Jurisdiction

Mander (2004, p.133) suggests that the 'context in which decisions are made is crucial to being accountable, in that if a midwife practises on the basis of possessing expert knowledge she/he must be able to do so without constraint'. However, the framework of legislation that protects the public in the UK system (NMC, 2012) and limits the role of the midwife to a professional who is responsible for low risk midwifery care, appears to call into question her/his autonomy, particularly in a high risk field, as it may restrict her/his ability to make decisions in that field. A central tenet of a midwife's habitus, as I have already referred to in previous chapters, is the belief that birth is normal and their responsibility rests with the care of low risk women; should women become high risk the midwife's remit is to refer the woman to an obstetrician (NMC, 2012). The belief that the care of women at high risk of complications are cared for by an obstetrician appeared to grant them authority and symbolic status and power in the field at the expense of the midwives.

Bourdieu suggests that identity/habitus is acquired through a symbolic struggle for recognition and that all identities have a degree of symbolic capital: being recognised is implicit in the concept (Swartz, 2013). All of the midwives interviewed at both Springdale and Northvalley appeared to be committed to facilitating normal birth (they spoke about '*facilitating women to do it themselves*' [labour without intervention] (Rachel B71N) and had '*high rates of vaginal birth*' for all women that is equated with midwifery practice, regardless of their risk assessment. However, the impact of practising in a high risk field appeared to have 'blurred' some midwives ideological view of child birth, in that it related to both a medical and midwifery perspective. Hazel (B72N) suggested that although she felt birth was risky, the midwives endeavoured to give '*midwifery care*':

I mean basically it's a baby's life. I mean birth is very risky but I think all the women here and the midwives that look after them have their midwifery care with them.

(Hazel B72N)

Hazel (B72N) appeared to imply that although birth was associated with risk, the midwives remained able to give basic midwifery care, such as support and other strategies to facilitate vaginal birth, such as 'mobility and 'nutrition'. Beverley (B72N), a LWC, also appeared to have accepted a pragmatic, middle way even though she was currently practising on the birth centre facilitating care for low risk women:

If I was going to label myself I would probably be, given the journey that they [women] need until it [the baby] comes out and then I'm an outcome [person] but actually I'm probably more, let's get you a healthy baby, but I do completely understand about the outcome and the control and all that kind of stuff. I think...I suppose I'm a bit a more pragmatic. Life never gives you what you want. Why should it in labour?

(Beverley B72N)

Both Hazel (B72N) and Beverley's (B72N) views appear antithetical to the usual ideological discourse of midwifery that suggests the journey is as important for the woman as the outcome and the belief that women are capable of giving birth without intervention. Their beliefs may have been affected as a consequence of practising in a high risk labour ward and resonates with what Kirkham (1999) suggested, that midwives practising on labour wards assumed the dominant medical discourse. However, I would suggest that the LWCs had adjusted the midwifery discourse to incorporate the medical aspect of their work rather than assume the medical discourse in its entirety.

The LWCs may also have adopted the language and habitus of the obstetricians in order to enhance their symbolic cultural capital by demonstrating a habitus that was recognised and attributed capital in the field. The boundary between obstetrics and midwifery are however, blurred. The midwifery discourse at Northvalley appeared to have been polarised by the opening of the birth centre. The continued rise in the number of birth centres may make this an issue for more midwives across the country

in the future. Since the opening the midwives on labour ward care and advocate for mainly high risk women and their close proximity to these women appeared to facilitate a sense of responsibility for them. The LWCs perceived the high risk women to be disadvantaged as they were less able to receive one to one care from a midwife that is associated with a reduced need for analgesia, greater satisfaction and normal vaginal birth (Hodnett, Gates, Hofmeyr and Sakala, 2013) and access to other facilities that may have ameliorated their stay. Thelma (B72N) suggested:

They [the low risk women on the birth centre] were getting a nice setting. They were getting the MP3 players or the docking stations, the birthing balls the nice curtains and I felt quite strongly that was very unfair and that it should be equal. Just because they [the women on the labour ward] are high risk, it doesn't mean they can't have the nice soft furnishings in pinks and purples as well. I am all for the high risk ladies.

(Thelma B72N)

Whilst the LWCs were practising within their professional code by advocating for the high risk women (NMC, 2015a), if they are not committed to their professional philosophy their cultural capital and position in the field may be lost. The clinical leadership literature (Redwood et al., 2007, McNamara et al., 2011) suggests the clinical nurse leaders' position in the middle of the hierarchy and their central task of coordinating work to facilitate the smooth running of practice also renders their contribution and professional identity invisible.

In the past the alignment with obstetric care and the development of advanced labour ward skills by midwives, such as being able to suture, scrub in theatre and facilitate high risk care were viewed as positive attributes. The knowledge continuum and the advancement of practice for nurses and midwives as the literature (Donnelly, 2005, Carryer et al., 2007) suggests is hierarchical as it is associated with the adoption of medical skills. These skills accorded symbolic cultural capital to the midwives who practised them. However, over the past twenty years, with the advancement of midwifery research and the push towards woman centred maternity services, that are responsive to women's needs, these skills, (although may be valued in the field),

have been superseded by a swing towards developing a more 'low tech' approach to facilitating normal birth. This appeared to have led to midwives practising on labour ward being negatively perceived and the skills that once gave them symbolic cultural capital were worth less within their profession. This was illustrated when Thelma (B72N) recounted an incident where a woman was unhappy with regard to the prospect of giving birth on the labour ward rather than the birth centre:

I feel by the time we discharged her [the woman] to the ward, she wasn't very happy that she wasn't going to the birth centre but at least she understood that we weren't the Devil on labour ward.

(Thelma B72N)

There appeared to be some evidence that high risk care was perceived as bad and low risk, as good. The practice of midwives on labour ward was therefore bad. Donna posited:

I think medicalised is bandied around as a negative word in midwifery but I think, pointless intervention in the name of medicalization like an ARM [artificial rupture of membranes] at four centimetres [cervical dilatation] for everybody or an episiotomy for everybody. No, absolutely not. It's not appropriate. It's not the right thing to do but medicines have helped women have healthier births, safer births and better outcomes and you can't move away from that. I think that's a non-moveable fact and I think, so if I'm deemed to be medicalised because I support those things and they're the right thing, then yeah, but I'm not for unnecessary interventions.

(Donna B72N)

The LWCs and midwives on labour ward appeared to experience 'professional dissonance' as did the midwives in Deery et al's. research (2010, p.50), as they were attempting to simultaneously hold two contradictory sets of values. The LWCs lacked recognition of their practice as midwives and found it challenging to practice in a high risk field as the reality of their work did not reflect their espoused midwifery habitus or sphere of practice (NMC, 2012). Fraser (2000, p.108) suggests that:

'To be denied recognition or to be 'misrecognised' is to suffer both distortion of one's relation to one's self and an injury to one's identity.'

(Fraser, 2000, p.108)

A tension appeared to exist as the LWCs and other midwives practising on labour ward, on the one hand were responsible for the care of women perceived to be at low risk of complication, and yet were also highly involved in the provision of high risk care. Norris (2001) suggests that the employment of the same practises by different professionals may render distinguishing between them difficult. It may blur the boundaries between each profession and may make it difficult to lay claim to jurisdiction over particular practices. Jurisdiction is associated with symbolic cultural power and suggests that whatever cultural capital that the midwives possessed may be weakened by a lack of jurisdiction within the field. Occupations may claim enhanced cultural capital if they are perceived as being able to do something that other professions cannot do e.g. midwives care for women at low risk of complications and obstetricians the women at high risk.

Facilitating midwifery care in a high risk field appeared to be difficult as it was not in the midwife's gift to lead women's care, although the Department of Health (2010b) suggest that midwives should be responsible for coordinating the care for women perceived to be at high risk of complications. Flint (1998, p.24) suggests that:

'The role for which midwives are trained does not exist.'

Whilst there are roles for midwives in birth centres, social enterprises, independent midwifery and in community, within the hospital, Flint's (1998) statement may continue to have some resonance. The recognition of the personal dignity of all individuals appears to have currently displaced the recognition of economic equality as the necessary prerequisite of a just society (Honneth, 2001) and therefore is important. Honneth (2001) suggests recognition is a political sign of social and cultural respect. Being recognised is also concerned with possessing cultural capital, as those who are recognised have individual authenticity and more power and control as a consequence (Bourdieu, 1993). Misrecognition may 'act to undermine a positive

sense of self' that may be vital for 'self-empowerment' (Fisher, 2008, p.583). The LWCs' misrecognition appeared to have impacted negatively upon their perceived habitus and influenced the use of strategies to protect and redefine it.

Dysfunctional Relationships

The midwives, obstetricians, paediatricians and anaesthetists on both sites appeared to work in professional silos. During my observations at Springdale, I rarely saw an obstetrician and although there were several occasions when labour ward was not busy I anticipated that I would observe some hand-over between both professions to discuss their workload or the women in their care. The midwives appeared to have an agreement that they '*only called the obstetricians (or other medical staff) when they needed them*' (Nicola B71N). The midwives appeared to have disassociated themselves with the more medical aspects of the labour ward work when they suggested:

Oh no we don't have anything to do with caesarean sections – we are a labour suite.

(Fieldnotes Springdale, 21.02.13)

Disassociating themselves with the work that was perceived to be medical appeared to be a way of practising within their own professional philosophy and enhancing their cultural capital in the field. The boundaries created by this may be important to re-establish the midwifery contribution to care. It can be suggested that the segregation of spaces and people are associated with power. The midwives at Springdale appeared to have minimal contact with the obstetricians. I observed on three occasions a group of *two or three obstetricians coming to the labour ward office and looking at the white board to discuss their workload for the day* (Fieldnotes Springdale, 21.02.13, 30.09.13, 4.10.13). I observed the *LWC speaking to the obstetricians* on one of those occasions. However, on the others neither the midwives nor the obstetricians appeared to communicate with the other, whether women were being cared for on labour ward or not. The midwives did not appear to be familiar with

how the obstetricians practised as the LWC was the only person that was aware which consultant obstetrician took the lead for labour ward:

I asked two of the experienced Band 6 Midwives which obstetrician was responsible for labour suite but they did not know "They [the obstetricians] never come", "They spend little time on labour ward".

(Fieldnotes Springdale, 21.02.13)

Whether or not the distance between the midwives and the consultant obstetricians gave the consultants a mystical, untouchable quality that Irene (B71) described in chapter five (p, 144) is not clear. I observed on one occasion what appeared to be a personal relationship, with a less senior (than the consultant), female obstetrician who had returned to work following maternity leave:

A junior obstetrician arrived in the staff room and was greeted with smiles and hugs. She had returned from maternity leave to finish her studies. She shared photographs and also had a conversation with one of the senior midwives with regard to her bereavement. There were tears and hugs.

(Fieldnotes Springdale, 21.02.13).

However, the relationship appeared to be a personal one between women, rather than professional.

In contrast to Springdale, the midwives at Northvalley appeared to be accustomed to the obstetricians' constant presence. I observed the presence of both obstetricians and anaesthetists at every visit to the labour ward. The midwives discussed social events and had conversations with doctors:

The LWC in charge on nights joked with obstetric registrar about his side burns and how midwives pronounce names of some of the other doctors' names.

(Fieldnotes Northvalley, 06.06.13)

However, Amanda (B62) suggested within the multidisciplinary team there were 'different entities' that had their 'own teams'. Practising in professional silos may be attributed to weak leadership within the NHS which inhibits the creation of a culture in which people feel safe. Silos are then created where clinicians are forced to practice in:

'small tribes to protect and advance their own interests...politics entrench, mistakes are covered up instead of exposed, the spread of information slows and ceases and unease soon replaces any sense of cooperation and security.'

(Sinek, 2014, p.23).

The field may then become less safe. The culture within the field may not be directed to facilitating safe care but geared to safeguarding the symbolic cultural capital of each group within it.

'Keeping the Doctors Out', 'Pushing Boundaries'

Gina (B72N) suggested that keeping the doctors out of a woman's room and trying to normalise care was '*challenging*' and a '*battle*' at Northvalley and may have been related to the enhanced symbolic cultural capital in the high risk field that the obstetricians now appeared to possess, that gave them greater access to the women. Preventing the obstetrician's access to women was perceived as '*pushing the boundaries*' (Gina B72N) as a means of facilitating normal, safe care for women and guarding their professional habitus. There appeared to be a 'tug of war' taking place at both sites between the symbolic cultural capital invested in the midwifery and medical discourse and the control of the field:

You [LWC] just want to push the boundaries a little but it's like, not everything's always black and white, you know, it's like, just leave them [the women] alone. They'll [the women] deliver. It's like trying to keep the medical staff out, trying to, you know.

(Gina B72N)

Andrews and Shaw (2008) suggest that:

'Space has been conceptualised beyond its geometrical or mathematical dimensions, as having social consequences and qualities, particularly with regard to its' navigation and occupation. Meanwhile places have been understood beyond being locations and points, as possessing meaning, attachments and identity, and hosting and representing human agency, interactions and cultures.'

(Andrews & Shaw, 2008, p.464)

The LWCs at both Springdale and Northvalley employed the symbolic cultural capital to gate-keep the field to prevent the obstetricians from accessing women. The LWCs became guardians (see Fig. 1) of the labour ward environment as well as the professional identity of midwives practising on labour ward. Most of the LWCs and midwives spoke about '*keeping the doctors out*' (of labour ward and the women's rooms) (Selma B51, Stephanie B61, Judith B752N, Hazel B72N, Nicola B71N, Valerie B71N) as a means of preventing them from interfering with the birth process. The LWCs did not appear to trust the obstetrician to refrain from unnecessarily intervening in the care of women. Beverley (B71) suggested:

They [the obstetricians] don't mean to, but they make everything else high risk.

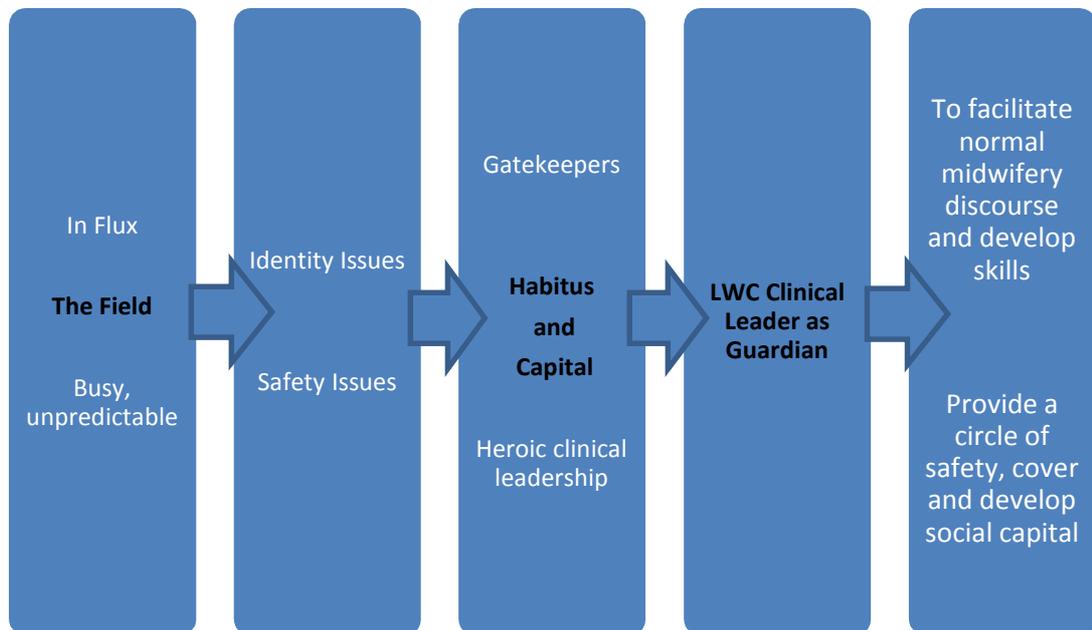
Gina (B72N) described how she prevented the obstetricians accessing women on the ward round:

*I don't take them [the obstetricians] in to see the women that have just come in for an epidural that are low risk. I don't mind them [women] being seen on the [ward] rounds but what I object to is when midwives come to **me** [emphasis is Gina] to tell me something, they [the obstetricians] will then sort of jump in with their two-penneth [contribution] or whatever and I'll say, **I'll** come, **I'll** see sort of thing, and you know, it's difficult.*

(Gina B72N)

By 'keeping the doctors out' the LWCs appeared to be protecting the cultural capital invested in their midwifery habitus and discourse as they were able to keep women's labours normal. Foucault (1991), as I alluded to earlier in chapter five (p.170), suggests that power is bound up in the control of space and surveillance. The LWCs controlled the space and deny the obstetricians of their medical gaze that appeared to reduce their cultural capital by rendering the women's space more private and out-with their control.

Fig 1: Guardianship and the LWC.



Fahy (2008, p.12) suggests that 'birth territory' reflects the geography and architecture of the space within which women labour and give birth and is also concerned with power and control and the people who occupy the space. She suggests that birth territory is a subjugated discourse as it is dominated by medicine which suggests science is superior to nature and the effect of the environment within which women labour and give birth is unimportant. However, there appears to be growing evidence with regard to the benefits to women and babies, of protecting the labour environment to facilitate undisturbed birth to challenge the medical discourse (Odent, 1999, Taylor, Klein, Lewis et al., 2000, Uvnas- Moberg, 2003 & Carter, 2003). The creation of a safe place in which women give birth may facilitate the reduction of fear in the woman and enhance her progress in labour.

Bourdieu (1993) suggests that the struggles within the field centre on the control of legitimate authority and the LWCs' legitimacy was perceived to be the prevention of intervention to protect women. Marion (B51) suggested the LWCs wanted '*what is best for the woman*', '*it's always about the women*'. Vinzant and Crothers (1998)

suggest that if power is to be perceived as legitimate (or part of the orthodoxy) it must be employed in the pursuit of a purpose or values that are themselves legitimate. Vinzant and Crothers (2007) suggest that the exploration of values may facilitate the understanding of a leader's decision making and use of discretion in the difficult and often complex environments that public servants work in that are often bound by the policies and governance that are in place to mitigate risk. A legitimacy that is associated with 'goodness' may be associated with enhanced power and an ability to impact upon others, which is resonant of Mannix et al's. (2015, p.2655) study that suggests 'effective goodness' is an aesthetic quality of clinical leaders that may facilitate calm in difficult situations. The perception that normalising care is good for women and babies may have facilitated the LWCs ability to control the obstetrician's action. Flint (1988) suggests that midwives possess discretionary power as she/he carries out the work and can challenge particular forms of care however:

'It must be said that some midwives are going to have to be brave enough to stand up in this way.'
(Flint, 1988, p.31 and p. 32)

Should the LWCs assume the responsibility for challenging care they may require support. Other professionals who hold power may also be required to accede or relinquish some power themselves. The drive to keep obstetricians away from women, however, resulted in the LWCs pushing boundaries, because of, and resulting in, the dysfunctional relations between the two professional groups.

However, Gina (B72N) spoke about how '*hard*' it was to challenge obstetricians and prevent them doing something. She recounted an incident where an obstetrician decided to perform a caesarean section to facilitate a baby to be born and her intervention prevented this:

The doctor wanted a section [caesarean section] ...she [the woman] was three centimetres [the neck of the woman's womb was three centimetres dilated]. I said, "Well we need to pH her". "I won't pH her" [doctor] and I said, "Well it's outrageous if you don't pH her before we do a section [caesarean

section]”...and she had a normal delivery. The tracing [cardiotocograph trace] became alright and I knew the consultant who was coming on would be very pro normal.....so you know, but it’s difficult.

(Gina B72N)

Gina’s difficulty appeared to highlight the inequality in symbolic cultural power between the obstetricians and the LWCs. Although, she was able to facilitate the type of care she perceived to be correct the obstetricians’ greater power made it difficult. Pushing boundaries was associated with facilitating normal midwifery care in the high risk environment and suggests that their professional habitus and identity was bound up in a struggle to become part of the orthodoxy in the field. The LWCs pushed boundaries by trying to manage the women without the intervention of the obstetrician that may be equated with risk taking, and appeared to place them in a precarious position. Nicola (B71N) stated:

I do like to sort my own problems out and everything else but I will involve doctors. I’m not gung–ho [over- zealous] like that but sometimes you’re better off trying to sort something out before involving them [the obstetricians] because it’s better to avoid interventions, if you can.

(Nicola B72N)

Interestingly, the clinical leadership literature suggests that risk taking was least associated with clinical leadership in nursing (Mannix et al., 2015). It was suggested by Mannix et al. (2015) that this may have been a gendered response, however, risk taking was evident amongst the LWCs on both labour wards. At Springdale I observed that the obstetricians were not always consulted when decisions were made with regard to care:

During the shift there was discussion regarding removing the electronic fetal monitor from a woman being induced with her thirteenth pregnancy, to facilitate her to become mobile in an attempt to stimulate her contractions.

(Fieldnotes Springdale, 21.02.13)

The LWCs described a lack of experience on the obstetricians part influenced their interference in women’s care. Whilst observing at Springdale I was informed that the obstetricians:

...don't have the expertise to perform external cephalic version (ECV), nor did they [obstetricians] try very hard so most women with breech babies have caesarean section.

(Fieldnotes Springdale, 30.09.13)

The LWCs on both sites appeared to experience difficulty with their relationships with the less experienced obstetricians. Although I did not observe this behaviour, several of the midwives on both sites gave examples without specifically being asked. Gina (B72N) suggested that these obstetricians '*would not be questioned*' (Gina B72N), '*overrode*' (Carmen B62) decisions without saying why, but saying, '*because I said so*' (Grace B62). The behaviour of these inexperienced obstetricians may have been an attempt to maintain their new status as doctors at the top of the hierarchy. However, they did not appear to '*recognise the experience*' (Sylvia B71N), of the LWCs which was probably greater than their own. The inexperience of some of the obstetricians appeared to exacerbate the tension that existed between the midwives and themselves. The lack of recognition and respect for the LWCs these doctors demonstrated appeared to reflect the discriminatory nature of the hierarchy in the field that provides capital to those who may be less worthy of its investment and the unequal share of symbolic cultural capital.

The LWCs appeared to have to push the boundaries to ensure that the midwives practising on labour ward developed the prerequisite skills for the field. Midwives are required by their professional body rules and standards (NMC, 2012), to possess the ability to manage complex care, such as breech and twin birth in the absence of medical support. When labour ward and the obstetrician are '*busy*' (Hazel B72N) or '*forty minutes away*' (Gina B72N) the LWC and midwives were required to employ these skills. However the ability to facilitate other midwives experience of complex birth appeared to require the discretion of the LWC that appeared to be fraught with danger. One of the dangers appeared to come in the form of sanctions when midwives attempted to use their discretion; Gina (B72N) stated that she had '*been reported [to a consultant obstetrician] before for not letting a doctor into a twin*

delivery', and therefore in breach of the local protocols and guidelines that suggested obstetricians are involved in complex care. Judith (B72N) also suggested:

The midwives will come to us [LWCs] and say, "I am bit worried about this woman and we [the LWC] will go in and we'll see what we think. We don't just, if somebody came to me we don't just say, "I'll go and get the doctor". So we will try and manage. Even when things are starting to go a little bit awry we will still try and manage things ourselves. I mean it's a very busy unit as well so there have been many, many situations when the doctors haven't even been available because they have been in theatre or been doing something else and we have had to manage difficult situations, and we do it with, you know, in the best way that we can.

(Judith B72N)

The midwives occasionally kept the doctors out of the woman's room when the care was perceived to be complex in an attempt to give midwives the opportunity to develop advanced skills, such as the birthing of breech, twins and making judgements as to whether instrumental birth was warranted or whether the '*baby would be born without*' this assistance'¹³ (Valerie B71N). It appeared that if the obstetrician was called she/he was compelled to act and the LWCs did not appear to have sufficient symbolic cultural capital to prevent her/his action. The obstetricians were not trusted, '*not*' to intervene (Nicola B71N). Gina spoke about a midwife who called the obstetrician to see a woman rather than the LWC and suggested that *I can't blame him [the obstetrician for acting] because you asked him...but you should have come to me [LWC] first.* (Gina B72N). It appeared that the midwives and obstetricians were in direct competition for experience and what appeared necessary to facilitate midwives' experience was to actually prevent the obstetricians from being involved. It suggested that the struggle for symbolic cultural capital in the field resulted in the midwife and obstetrician being unable to work together to share learning, responsibility and potentially deliver safer care.

¹³ Some babies can become distressed in the final stages of labour as they are being pushed out and it can be difficult to assess whether using instruments to facilitate the birth would be quicker or encouraging the woman to push. The use of forceps can cause significant trauma to the woman, baby and the father but may also speed up the birth significantly so that the baby's distress does not worsen.

The development of dysfunctional relationships and an inability to practice within a multidisciplinary team is reminiscent of what happened at Furness Hospital that is part of the University Hospital Morecambe Bay NHS Foundation Trust. The Morecambe Bay Investigation (Kirkup Report, 2015) examined the deaths of mothers and babies between the first of January 2004 and the thirtieth of June 2013. It reported that poor working relationships existed between the obstetricians, midwives and paediatricians that resulted in them being unable to work together. Kirkup (2015) found senior midwives who appeared to pursue 'normal' childbirth at any cost and a strong group of midwife 'musketees' (p.8) that drove this by keeping other people away and pushing past boundaries. Although a '*gung-ho*' (Nicola B71N) approach was not found in this study similarities regarding the midwife/doctor relationships were apparent. A lack of trust between health professionals and a lack of collaboration has been seen in the past to result in poor outcomes for women (Knight, Kenyon, Brocklehurst, Neilson, Shakespeare, Kurinczuk, 2014). It could be suggested that the battle for symbolic cultural power in the field between obstetricians and midwives may not be in the best interests of women and their families.

The morbidity for women associated with medicalised childbirth is well known and acknowledged (Leap & Anderson, 2008, Walsh, 2007). The concern shown by the LWCs to normalise birth for women and prevent the 'cascade of intervention' appeared legitimate and of value. It would therefore appear logical that this discourse should be an inherent part of the orthodoxy within the field. However, the symbolic power invested in the medical discourse appeared to create the inequalities in the field and led to the midwives taking risks and practising their midwifery discourse through stealth. Swartz (2013), referring to Bourdieu's accounting for symbolic power, suggests that as a consequence of symbolic power:

‘...inequalities are misrecognised as natural and inevitable and the social effect is to reinforce and reproduce social hierarchies. Hence symbolic power performs symbolic violence by disposing individuals and groups to accept without contest in egalitarian arrangements.’

(Swartz, 2013, p.100)

Whilst the LWCs did not appear to wholly accept the medical discourse the imbalance of power in the field prevented them from realising the potential of their own midwifery practice and the potential for improving women’s care in childbirth.

As has been suggested the apparent tension between the medical and midwifery discourses did not appear to facilitate the midwives’ ability to give care in the field. Whilst this study only considered the midwifery perspective, the debate surrounding the two ideologies appeared to be perceived as *counter-productive* (Donna B72N). The move towards professionalization and the symbolic capital associated with professional status appears to have situated midwives and doctors as adversaries in a struggle to determine which discourse is best adopted to give effective care to women and their babies. However, Grace (B62) and Beverley (B72N) suggested that what appeared to be important was what ‘was *best for that particular woman*’ (Grace B62) or ‘*individual woman*’ (Beverley B72N). Gilmour (2005, p.19) suggests the notion of ‘hybridity’ may be a useful term to employ to refer to the processes that transform and realign the ‘conceptual boundaries between discourses’ that are perceived to be different. Hybridity may be useful to ‘produce something that is ontologically new’ (Rose, 2000, p.364) that facilitates both midwives and obstetricians to practice together in the best interests of women.

Summary

This final findings chapter examined the habitus and capital of the LWC, her impact upon the field and the agency of the other midwives practising within it. The struggle for recognition and symbolic power within a field in flux, as well as the strategies the LWCs employed to protect both their professional habitus and capital were also

considered. The LWCs' clinical leadership habitus appeared to be socialised over time through the experience of holding an 'acting' LWC position or being a 'Wing Man', rather than being formally taught. Although learning to be a LWC did not appear to be prescribed or forced, the correlation of practice with family, love and home may have contributed to the LWCs' practice attracting greater symbolic power. The socialised LWC practice offered a sense of security and ownership in what appeared to be an unsafe, changing, scary, conflictual field and may be why it was perpetuated.

The symbolic power invested in the LWC in the unsafe field and the socialised nature of clinical practice was a means by which the agency of the midwives was either enabled or constrained: it reduced their cultural capital, inhibited resistance, prevented change and increased their conformity with the prescribed norms and doxa in the field. However, the LWCs were consulted by the other midwives rather than making all the decisions. Nonetheless, the responsibility and power invested in the LWC meant that she had the final say. The inexperienced midwives within a scary field appeared to require the cover (and therefore power-over benefits) of the LWC until they acquired the necessary labour ward skills and therefore deferred more readily. Working within the prescribed doxa of the field kept midwives safe although increased the accountability of the LWC. The reliance on the LWC appeared to turn them into imaginary Gods who were concerned that they had to know everything. Applying the principle of good-enoughness may avoid reliance on the LWC and foster midwives to learn how to manage however implicates the sharing of power and responsibility.

Whilst some midwives preferred the cover of the LWC, some of the more experienced midwives appeared to resent their constrained autonomy. Resistance was apparent on both sites in the field, however, did not appear to be common. Whether the midwives were afraid to dissent or whether symbolic violence was present in the acceptance of the LWCs symbolic power in the field was not clear. At Springdale the

measure of the LWCs symbolic power was understood by their ability to enforce silence, inhibiting change until the LWCs retired. The difference between the LWCs' symbolic capital at both sites may have been due to the balance of power being tipped in favour of the obstetricians at Northvalley. The midwives appeared to have the choice of accepting the doxa within the field and fitting in or being outside the group. It was suggested that midwives who complied with the LWC engaged in inauthentic thinking, however, they appeared to lack the capital to affect change in the field. Autonomy and agency appeared to be a matter for the LWC which appears to be at odds with clinical leadership that espouses a more democratic approach. Socialised practice appeared to undermine professional practice by inhibiting reflection and the questioning of practice and therefore, formal clinical leadership education appears to be implicated to inform the development of leadership practice that embraces change and the provision of effective care.

The changes in the field that led to a balance of power in favour of the obstetricians appeared to result in a struggle for symbolic power and control. The changes challenged the midwifery discourse as they called into question midwifery identity, jurisdiction and therefore symbolic capital in a high-risk field. The LWCs experienced professional dissonance, as their position in the field predicated the adoption of a pragmatic approach to their practice that required them to possess skills for both midwifery and high risk practice. However, the alignment of their advancing practice with medicine reduced their cultural capital within the field and was associated as bad. The dysfunctional relationships that existed within the field appeared to be manifest of professionalism, a lack of trust and disrespect and symbolic violence through misrecognised gendered power relationships.

The LWCs developed strategies to retain their symbolic cultural capital in the field by employing their discretionary power to keep doctors away from women. Despite evidence to suggest that the normalisation of care for women was beneficial, and

therefore should be afforded cultural capital, and that unnecessary medical interventions caused harm, the LWC fought a battle to implement midwifery in the high risk field. The LWCs engaged in risky practice, with negligible support, to facilitate normal birth for women and accrue the clinical skills required in the field. The data suggest that inequalities of power between the obstetricians and midwives and a discriminatory hierarchy that conferred capital on position over skills and experience existed in the field. The competition for experience and the struggle for symbolic cultural capital appeared to prevent midwives and obstetricians working together to share learning, responsibility and facilitate safe care for women, which may not be in the best interests of women. It appeared that the midwifery discourse, that may have been an important and integral part of the orthodoxy of the field, was on the periphery. Obstetricians and midwives appeared to be adversaries. What appears to be required is the development of something hybrid that realigns the boundaries between the two discourses and facilitates woman-centred leadership and power-sharing, not only amongst professionals but with the women who use maternity care.

CHAPTER EIGHT: DISCUSSION OF THE FINDINGS

Introduction

This chapter will discuss the main findings of the study and its strengths and limitations as a prelude to presenting the conclusions, making recommendations for policy, practice, education, future research and the dissemination of the findings in chapter nine.

The Contradictions of Clinical Leadership on the Labour ward

Collinson (2005, p.1419) suggests that 'in contemporary Western societies leadership issues are frequently understood in binary terms': leaders are either represented as heroes or villains. However, Collinson (2005, p.1436) also suggests that the identity of leaders and relationships of power within leadership are more frequently being perceived as 'blurred, multiple, ambiguous and contradictory'. The findings of this research with regard to the identity of the clinical leaders and their power relationships reflect what Collinson suggests.

Heroic *and* Values-Based Clinical Leadership

Chaos, Risk and Heroism

The environment of the labour ward (field) had significant influence on the way the LWCs practised clinical leadership and the capital they possessed. Both labour wards were described as 'scary', 'unsafe', 'unpredictable', 'busy', 'relentless', 'high risk' places and care-giving was likened to a 'battle' that demanded 'camaraderie' through a sense of danger. Followership was driven by fear in the high risk labour ward and the reliance on a strong, masculinised, heroic clinical leader who would keep them safe. Possessing masculinised characteristics may have been a prerequisite for the maintenance of the LWCs' position in a hierarchical environment dominated by

masculinised, scientific practice. The acceptance of strong clinical leadership led to a tolerance of bullying, behaviour and although bullying was not associated with the 'good' LWCs it gave credence to the scary behaviour of some of the LWCs. The RCM 'Caring for You' Survey (2016, p.8) suggests that high workloads and long shifts may be responsible for 'bullying, harassment and undermining behaviours' that was also found in this research. Bullying may have been a mechanism that some LWCs employed as a means of getting the work done quickly without having to invest in values-based practice or developing social capital and passion in their followers that may have required more of them. However, the NMC (2015b, 2012) mandate the professional behaviour of midwives to possess an intolerance of 'abuse or neglect' (NMC, 2015b, p.2) and an inherent responsibility to raise and escalate concerns when they arise. The tolerance of poor behaviour and acquiescence to strong clinical leadership appears to represent the importance placed upon safety and the fear experienced by some midwives with regard to becoming unsafe.

The fear created by the 'high risk' environment, however, may be misplaced. Whilst the National Maternity Review (2016, p.21) recognises that the continued rise in the birth rate and the rise of co-morbidities in women, such as diabetes, that may render their care more complex and labour wards risky and busier, it also states that the 'quality and outcomes of maternity services have improved over the last decade'. The low and high risk labels attached to women are not predictive of outcome (Saxell, 2000) and therefore do not reflect the type of care women may need in labour and who they require this from. Kitzinger (1998) and Walsh, El-Nemer and Downe (2008) suggest that risk is driven by beliefs around safety and that women may view safety very differently to health professionals. Women's safety may be related to a sense of control and may perceive risks to be lower than the midwife or the obstetrician (Stahl and Huntley, 2003). Women who have a positive outlook on their pregnancy may

also birth more easily without intervention due to the impact their positivity may have on the production of labour hormones (Fahy & Hastie, 2008).

A woman assessed to be at high risk in labour exposes her to interventionist practices and unnecessary medical interventions that are associated with further intervention and increasing morbidity for both women and their babies (Walsh, 2007). Women at both high risk and low risk may benefit from midwifery care that considers the building of relationships with women and their families and providing one to one, continuity of care and carer that is associated with fewer obstetric intervention and a higher rate of spontaneous vaginal birth (Hodnett, Gates, Hofmeyr, Sakala, Weston, 2013). Inappropriate risk assessment may therefore unnecessarily fuel the fear experienced by clinicians and women. The rise in the birth rate anticipated in the near future and an ageing midwifery workforce that is predicted to result in a loss of midwifery skills and expertise (The National Maternity Review in England 2016) is also likely to further increase staffing pressures and skills set within the labour ward. All of these issues may contribute to the continued reliance on heroic leaders and hinder the development of collaborative and democratic clinical leadership.

The LWCs' clinical leadership was inherent in their visible engagement in practice that provided support for other midwives, their position and responsibility within the hierarchy; their advanced clinical acumen that facilitated the management of emergency situations; their ability to co-ordinate, calm and control the busy labour ward environment and their possession of a sense of duty, self-sacrifice and courage. The coordination of the labour ward was prioritised by the LWCs when practice became chaotic, over the type of clinical leadership that involved facilitating the giving of direct care to women through the support and guidance of other midwives. Productivity and safety were therefore prioritised over innovation. It may be that in a context driven by fear and safety, where decision-making is often urgently required

that it may be difficult for clinical leaders to both coordinate activity and offer support to midwives to develop their practice.

Unrecognised Professional Autonomy and Agency

Endowing the LWCs with symbolic cultural capital and the responsibility for the labour ward rendered them vulnerable to being accountable for the action of others. This responsibility encouraged a desire to oversee and control the labour ward environment which in turn led other midwives to further defer responsibility and to comply with the LWCs' leadership. This vicious cycle appears to maintain and compound the problem of the lack of agency attributed to other midwives and the 'God'-like characteristics anticipated of the LWCs that meant they had to know everything.

The autonomy expected of midwives in their rules (NMC 2012) was at least partly deferred to the LWC in response to the often chaotic, life-death situations that require instant rather than time-consuming collaborative decision-making. Less-experienced midwives appeared to appreciate, in the short term, the power that the LWCs had over them as the LWCs possessed skills that they did not and kept them safe. Whilst resistance from more experienced midwives to the LWCs control was found it was rendered silent by a desire to be inside the group. Accepting and 'fitting in' to the 'way things were done' was preferable to being outside the group and indicates the symbolic capital and influence of the LWC, as well as the insularity of this group of midwives. It is naïve, however, to anticipate a lack of accountability as a professionally registered midwife and an overestimation on the part of the LWCs to perceive that accountability on the labour ward is hers/his alone. Nevertheless, the perception of the buck stopping with the LWC may be sufficient to perpetuate her/his need for control. The LWCs' clinical leadership behaviour is therefore a symptom of a system that is failing them.

The Importance of Social Capital and Values-Based Practice

In addition and in contrast to the LWC clinical leaders being perceived as strong and heroic, other characteristics that delineated the 'good' LWCs were values-based, transformational, aesthetic, more feminine: soft, rather than hard qualities, such as valuing others, humour, enhancing the clinical environment, motivating, teaching, and the development of teamwork and general reciprocity. Whilst LWCs possessed transformational leadership qualities, having a vision, that is a central tenet of transformational leadership theory, was not attributed to them. This finding concurs and therefore strengthens Stanley's (2008) congruent leadership theory that suggests the possession of personal values and practising in accordance with professional values, rather than vision; congruent leadership rather than transformational leadership may be what is required of front line clinical leaders.

In this study I consider values-based midwifery practice to be that which is based on valuing others, respect, motivation, clinical acumen and possession of a commitment to facilitating woman-focused, normal care. Values are elemental in health care as they are perceived to be benchmarks for professions (Duncan 2010, Cuthbert & Quallington 2008, Henry 1995). In the UK, midwifery's professional values are enshrined in the Code (NMC 2015a) and Midwives Rules and Standards (NMC 2012) and covet autonomy, advocacy and accountability, as well as situating midwifery responsibility within normal midwifery practice. However, Siddiqui (1996 p.88) comments that 'the realisation of these values in practice may be fundamentally flawed by an apathetic observance of them'. Variance exists in the values that individual healthcare professionals and different professional groups hold, be that in England, or in other countries in the world (Duncan 2010). In this study the variance in professional and personal values was evidenced by the blurred midwifery philosophy of some of the midwives practising within a labour ward (p.217). Changing workloads, a lack of experience of woman-centred services, such as the continuity of

care and the dominance of one set of professional values over another, may represent institutional barriers to practising in line with a person's values (Siddiqui 1997). Principles of advocacy may be perceived as less valuable than facilitating a smoother collaboration with the organisation or with those who are most powerful within it. However, if organisational values are perceived to be more valuable than professional values, the latter could be construed as being merely positive aims rather than what lie at the foundations of practice. The relationship between the LWC and the midwives mirrored the midwife-mother relationship described by Kirkham (2000). The LWC afforded cover and a 'circle of safety' for the midwives as strong, clinically able heroic leaders and at the same time supported them emotionally by creating 'calm' and being a 'port in the storm'. The social capital derived from the 'close knit' relationships, love and camaraderie on both labour wards, in addition to motivating passion for their profession and role modelling effective relationships, appeared to be a coping mechanism that facilitated productivity, safety, teamwork and the followership of the clinical leader. This social capital could also be construed as a means of manipulating the behaviour of the midwives for the LWCs' benefit. The close working relationships also enhanced the midwives' cultural identity and insularity, and led other midwives and doctors to 'fit in' to their ways of doing things which has the potential to stifle change. Being receptive to outsiders and a tolerance of dissent may be required of clinical leaders to challenge the insularity.

Maben, Latter and Macleod Clark (2006), although referring to newly qualified nurses applies equally to newly qualified midwives, suggest that they reach registration with a strong sense of professional values. However, the requirement to follow rules and a lack of support from role models who espouse the same professional values prevents these nurses/midwives from practising in line with their professional discourse and may be viewed as 'professional sabotage' (Maben et al., 2006 p. 465).

Health Education England (HEE) (2015, p.12-13) found that the new generation 'Y' and 'Z' of nurses and midwives have different expectations of their career than the generations of midwives before them. The new generation want to: 'work with you [the NHS], not for you' and expect: 'to be informed and you must listen and acknowledge my response' (HEE, 2015, p.12-13). The findings of the study suggest that if those new nurses and midwives are unable to get what they want from practice they are prepared to leave the profession (HEE, 2015). Values-based practice may therefore be important for leaders to role model if the transition from student to nurse or midwife is to be facilitated and to encourage their retention in the profession.

Deery and Fisher (2016, p.11), refer to 'values-based professionalism', that predicates practising in accordance with a person's professional values, as was the practice of some of the LWC clinical leaders. Displaying professional values in midwifery practice may lead to midwives' enhanced perception of their professional duty to women. The impact of values-based professionalism resonates with the virtuous circle I referred to earlier in the thesis (p.51) that is created when a health professional perceives to be valued and respected: she/he is subsequently more able to provide the same within the care for their client. Values-based practice may therefore also facilitate a woman centred approach to care that is empowering and respectful. The attempt to implement woman centred care has driven policy in the maternity services since the 1993 Changing Childbirth Report (DOH, 1993) and is reiterated in successive reports (DOH, 2007, Francis, 2013, Kirkup, 2015, England National Maternity Review, 2016) and mandated through professional regulation (NMC, 2012, 2015a). However, the successive drive for maternity care to become woman centred has yet to be realised, although, has the potential to become so if midwives perceive they have the power to practice in this way.

Clinical leadership on the labour ward incorporated both heroic and values-based practice. Although I suggested in chapter six (p.166) that heroic leadership appears

to be the antithesis of clinical leadership that is espoused to be collaborative and shared (The King's Fund, 2011), in the context of the labour ward environment, both heroic and values-based clinical leadership may be of equal importance. However, possessing both heroic (hard) and transformational (soft) characteristics to provide support for midwives and keep the labour ward safe impacted upon the clinical leaders. The multiplicity of their clinical leadership led the LWCs to engage in philanthropic emotion work and physical stress that left some feeling that they would 'die at work' and were at risk of being burnt out. The RCM's (2016) 'Caring for You' survey found high levels of stress and burnout in midwives and echoes the findings of this research that reveals the emotional and physical stress inherent in the LWC's position. The LWCs' emotional and physical labour and the lack of support also intensified their need for mutual support and the creation of a formidable group of women. It may be incumbent on NHS Trusts to develop mechanisms of support for all midwives and to demonstrate their appreciation of the work they undertake if they are to maintain the health and well-being of their work force and minimise staffing crises.

Combining Coordination and Clinical Support

A mechanism that facilitated the LWCs to simultaneously coordinate labour ward activity and provide support and guidance for midwives was the appointment of the 'Wing Man'. Either an experienced Band 6 Midwife or another LWC was designated as 'Wing Man' to support the LWC when the labour ward was busy. In addition to being a strategy to develop future LWCs the 'Wing Man' was recognised for the clinical support and guidance she/he offered other midwives. The 'Wing Man' represented the type of clinical leadership that was capable of enhancing the quality of clinical care, as it supported other midwives to give direct care to women. The 'Wing Man' facilitated the simultaneous coordination and clinical leadership of the labour wards. Clinical supervision may be implicated if the LWC is to manage her work

without physical or emotional harm. Deery (2005 p.164), suggests clinical supervision facilitates midwives to develop skills to: 'become more self-aware in their actions with clients and women' and that 'interpersonal skills and ways of managing emotions at work are essential to help midwives cope with the, often, stressful nature of their work'.

The Problem with Professional Socialisation

In addition to being a support for the LWC, the 'acting' LWC and the 'Wing Man' position facilitated learning how to become a LWC. The development of the LWCs' clinical leadership was achieved through experiential learning, rather than more formal education. Clinical skills development on the labour ward was more highly valued than academic learning which appears logical in the practice setting. Although practice skills development may be a priority on the labour ward, other forms of knowledge may facilitate effective decision making and support practice development for midwives and the women and families for whom they care. Being aware that one to one care in labour reduces the need for a woman to use analgesia in labour (Hodnett et al., 2013) may lead to its increased use.

A lack of formal preparation for clinical leadership led to practice that was socialised and the perpetuation of particular characteristics and ways of working that were difficult to change. Anticipating the retirement of some of the LWCs was perceived by some midwives to be the first opportunity for other midwives to facilitate change. 'Fitting in' and compromising their professional principles appeared preferable for some midwives than being outside of the group. Socialised practice does not appear to facilitate professional or practice development and appears to run contrary to the aspirations for clinical leadership that implicate team decision making and the empowerment of midwives to facilitate change and enhance the quality of care for women and their families.

Clinical leadership was a concept that the midwives in the study found difficult to define, as it was unfamiliar to them and they had not previously considered who the clinical leaders on labour ward may be. The unfamiliarity of clinicians with the term, the lack of a clear definition and a lack of preparation for clinical leadership resonates with the literature in chapter three (p.60) and suggests that the drive to develop clinical leadership in the NHS may be hampered if the clinicians at the frontline of care are unprepared and unaware of its potential or their capacity to be clinical leaders.

Power and the Lack of Legitimacy

Power and Legitimacy

Practising within the labour ward led the LWCs and other midwives to develop advanced skills along a hierarchical knowledge continuum, away from midwifery and towards medicine, to facilitate their ability to practice and legitimise their place in this environment. However, this appeared to blur their perception of their midwifery discourse that subsequently incorporated aspects of both the medical and midwifery model of care. The increasingly high risk labour ward that altered the balance of power in favour of the obstetricians exacerbated the professional dissonance for the LWCs and other midwives who found it difficult to reconcile their professional discourse that promotes normal birth, with working in this changed field. Whilst powerful, the LWC lacked legitimacy in a high risk field. The move towards facilitating low risk birth in birth centres may continue to render labour wards as high risk environments that alter the balance of power and where the midwives who practice within them may struggle to determine their identity or allegiance.

Nonetheless, in the fearful labour ward environment the LWCs were attributed symbolic cultural capital by others on the basis of their position which was perceived to be a necessary, normal part of labour ward practice and facilitated the LWCs' ability

to ensure the safe, smooth running of the labour ward. The LWCs' proximity to the labour ward environment and the women in their care also enhanced their discretionary power in the 'disconnected' hierarchy of the NHS (that suggests those at the forefront of care may have more power to impact upon it than those at the top). Rather than being power-less, as Kirkham (1999) suggests midwives are, the LWCs were a powerful group and therefore possessed the ability to influence decision-making and practice on the labour ward, which reflects the literature in chapter three (Spiby et al., 2013, Marshall et al., 2014).

The LWCs capital within the labour ward and their ability to role model values-based professionalism is an important opportunity for midwives to advance the recognition and legitimacy of midwifery practice and knowledge on the labour ward and within the maternity services. Having midwifery clinical leaders who espouse the values of their profession in a context dominated by authoritative medical knowledge is important in raising the profile of their profession and will facilitate the next generation of midwives to practice using the values they have been taught and possess. Values-based midwifery practice is vital if midwives are to emerge from medical domination, where they support medical practice but practice midwifery covertly. Practising in line with their professional values will facilitate midwives to assume their rightful place amongst obstetricians as professionals who are able to contribute legitimately to high quality maternity care on the labour ward.

Discrimination and Dysfunction

The development of midwifery practice towards medicine implicates a closer alliance with the obstetricians on labour ward. However, a functional, status, professional hierarchy also existed on both labour wards that located the obstetrician at the top and midwives below that was social and reflected divisions of class, rank and gender that were misrecognised and may therefore be perceived as a form of symbolic violence. The discrimination and symbolic violence implicit in the apparent primacy

of obstetric position over midwifery skills and experience, practising in silos and a disregard for the value of midwifery knowledge and discourse within the medical orthodoxy of labour ward practice appeared to place midwives and obstetricians as adversaries. The dominance of the medical model of care that is concerned with risk, illness, professional control and authoritative knowledge reflects the power relationships and context within which the midwives practiced. However, the reliance on positivist, evidence based medical knowledge to facilitate care giving may be inappropriate with the current move towards person-centred, individual care and collaborative inter-professional health practices (Maben et al., 2006).

As clinical leaders on the labour ward, the LWCs found themselves caught between facilitating obstetric practice and taking risks. The LWCs kept the obstetricians away from women to prevent unnecessary obstetric intervention and to facilitate their ability to work within their professional discourse or in a bid to develop the enhanced skills required to practice on the labour ward. Whilst some effective relationships between midwives and obstetricians appeared to exist there were others where obstetricians and midwives lacked trust and respect, were unable to share learning, responsibility or facilitate care in the best interest of women and their families. Dysfunctional and discriminatory relationships that are unethical do not facilitate collaborative working practices and do not serve the best interests of women and their families who may require the combined skills of both professionals to receive the most appropriate care.

Strengths and Limitations of the Study

Original Contribution

The purpose of this study was to explore clinical leadership on the labour ward. This research is relevant and important as clinical leadership is an emerging strategy that contends clinical leaders or bed-side leaders have the potential to facilitate change and make significant differences to the care and lives of the people with whom they

engage. Whilst leadership appears to be of significant importance within the NHS, a literature review found that midwifery leadership and clinical leadership were neglected areas of investigation. Few empirical studies have examined leadership within midwifery and none have focused on clinical leadership on the labour ward. This research is the first to examine the clinical leadership of midwives at the front line of care, clinical leadership on the labour ward and to employ Bourdieu's theory as an analytic tool. The thesis also contributes to front-line leadership literature in general and the findings support Stanley's (2008) Congruent Leadership Theory that suggests clinical leaders are determined by their values rather than their vision and that clinical leadership may be found at all levels within organisations (Stanley, 2006).

The research contributes to the development of the use of Bourdieu's Theory of Practice as an analytical tool in critical ethnographic study. As I suggested in chapter six (p.166), the findings of this study indicate that the labour ward environment was central to the development of heroic leadership: it impacted upon the development of social capital as a coping strategy and led to the misrecognition of the midwives and their subsequent risk taking. Whilst Bourdieu (2013) suggests that field, habitus and capital are of equal importance in the equation that represents practice, the field in this study appeared to have primacy. The field appeared to be more deterministic than Bourdieu implies. Whether particular fields, such as the high-risk, unsafe, life-death labour ward environment are more deterministic than others is unclear. The thesis also uncovered power-over relationships that appeared to confer some benefit to the least experienced midwives practising on the labour ward, that Swartz (2013) suggests Bourdieu does not consider. The thesis therefore adds to Bourdieu's work and the current rise of interest in it (Thatcher, Ingram, Burke and Abrahams, 2016).

The study was undertaken on two labour wards in separate NHS Trusts in the North of England, representing a district general hospital and a teaching hospital that were anticipated to comprise different power dynamics. The similarity of the data from both

labour wards appears to enhance their authenticity. This was a small-scale study and the context within the labour wards may not exactly represent others. However, whilst I did not aim to generalise the findings, they may be transferrable to some labour wards regionally, nationally and internationally.

Methods

The aims and objectives of the research were met.

Critical Ethnography

A critical ethnographic methodology and the use of Bourdieu's Theory of Practice facilitated my ability to meet the aim and the objectives of the research which were to:

- Critically explore clinical leadership on the labour ward in relation to power and professional discourses.
- Critically examine the characteristics attributed to clinical leadership.
- Critically explore the characteristics attributed to those clinicians identified as effective clinical leaders on the labour ward.
- Critically examine the experience of being a clinical leader on the labour ward

Using a critical ethnography facilitated the examination of inequalities and power relationships within the field of labour ward that impacted upon the practice of clinical leadership. Methods relevant to undertaking a critical ethnography were employed to address the aim of the thesis. The combination of observation and interviews facilitated insight into contradictions between what was said and observed and vice versa and at times drove the processes.

Bourdieu's Theory of Practice as a 'Critical' Lens

There is a lack of clarity within the research literature related to the most appropriate method of analysing critical ethnographic research. It appears from the literature and

the critical ethnographies I examined that coding and thematic analysis was usual, although, Carsprecken (1996) describes his own method. However, the application of Bourdieu's Theory of Practice (2002) to the themes of 'safety' and 'identity' that emerged facilitated the critical examination of clinical leadership practice. Analysing the data using the lens of Bourdieu's Theory of Practice clarified who the clinical leaders were, the context within which they practised and the power that they possessed in relation to others. Bourdieu's Theory of Practice is suitable for a critical methodology as it is conceived as a way of freeing people from their domination and a means of understanding the social world they inhabit. As I began by recognising the domination of midwives it helped to explain how a hierarchical system and medical domination impacted upon clinical leadership and to uncover discriminatory practices.

Reflexivity

Reflexivity is key to critical ethnographic study. Throughout the research reflexivity facilitated the trustworthiness and confirmability of the findings by acknowledging the potential effect I may have had on the findings and attempting to minimise this as much as possible. It was important to examine my own position of power in relation to the midwives I studied to facilitate my ability to equalise the relationship. Carsprecken (1996) suggests that unequal power relationships between the researcher and research participants may result in being unable to validate the findings. Acknowledging my own influences by being reflexive clarified how my own background and beliefs may have influenced the data. My own values-based view of clinical leadership at the outset of the research was at odds with the heroic leadership in the findings. My view suggested:

'A clinical leader in midwifery is a clinically credible midwife who has up to date knowledge, is able to guide and empower other midwives to positively influence appropriate midwifery care and who advocates for women'.

However, within an unsafe, risky labour ward environment both heroic and values-based characteristics may be necessary prerequisites for clinical leaders. It was useful in the writing of the thesis to have the support of my supervisors who were familiar with the subject and data and less so with the analysis as they were able to challenge my thinking and approach to it.

Limitations of the Sample

Observing the midwives giving care to women may have shed more light onto how the clinical leaders influenced decision making in practice, although this was not inherent in the aim and objectives, it may have highlighted the power relationships involved in the process. Including the views of the obstetricians on the labour wards may also have facilitated the exploration of the dysfunctional relationships that existed from their perspectives.

Summary

This research makes an original contribution to the literature regarding clinical leadership practice on the labour ward and to the use of Bourdieu's Theory of Practice as a means of viewing the findings of a critical ethnographic study. Employing a critical ethnographic methodology was appropriate and the reflexivity within it enhanced the trustworthiness and confirmability of the findings. The research found clinical leadership on the labour ward to be contradictory and gendered. The use of both, heroic clinical leadership to coordinate labour ward activity, and values-based clinical leadership, to support the development of other midwives was warranted in a high risk and fearful environment. However, fear and risk led the LWCs to prioritise coordination and safety over practice development. Fear was a barrier to clinical leadership. The support of the 'Wing Man' was an important strategy to facilitate the simultaneous practice of both.

Symbolic cultural capital was attributed to the LWCs' vital position and responsibility on the labour ward and lead to a reliance on their heroic, strong leadership, a tolerance of bullying and the loss of autonomy of other midwives. However, midwives do not have the ability to confer their professional autonomy to another clinician. The LWCs may have inaccurately perceived the weight of their responsibility, however, the perception contributed to the controlling characteristic of their heroic leadership. Enhanced support is implicated to assist the LWCs to manage the emotion and physical work inherent in their clinical leadership and render this group of midwives less controlling and formidable. The symbolic cultural capital of the LWCs and their ability to develop social capital and demonstrate values-based practice places them in an influential and important position as clinical leaders within the maternity services. However, a lack of understanding with regard to the concept of clinical leadership and its potential may prevent its development. A lack of formal preparation for clinical leadership lead to socialised professional practice that stifles change.

Through role modelling values-based practice the LWCs have the potential to raise the profile of midwifery skills and knowledge so that midwives are able to embrace their own philosophy in the labour ward environment; redress the balance of power to have equal standing with obstetricians; facilitate the transition and retention of a future generation of midwives who are able to use the values and skills they have been taught and to facilitate collaborative practice, where a diverse range of knowledge can be employed to develop a more individual, woman-centred approach to care. However, the hierarchy and discrimination within the labour ward that produced dysfunctional inter-professional relationships, risk-taking and the vulnerability of midwives and women needs to be addressed, if a democratic, collaborative style of clinical leadership is to be developed.

The following chapter will conclude this thesis, make recommendations for policy, practice, education, future research and outline a plan for dissemination.

CHAPTER NINE: RECOMMENDATIONS AND CONCLUSION

Introduction

Drawing on the findings discussed in the previous chapter recommendations for midwifery practice, education, policy and future research will now be considered. A proposal for the dissemination of the findings and recommendations will be outlined and the thesis will be concluded.

Recommendations

Recommendations for Policy

Reducing Risk and Fear on the Labour Ward

Reducing fear on the labour ward has the potential to prevent the over-reliance on a heroic leader who saves the day. Within the development of future policy in the maternity services the Department of Health should be required to consider the following recommendations.

- Recognising the imprecise nature of the risk assessment of pregnant women in national guidelines and recommendations for care should reduce fear amongst women and clinicians. A reduction in levels of fear is likely to prevent an over-reliance on heroic leaders who save the day. This in turn would facilitate the midwifery contribution to the care of those women deemed to be of high risk of complication by stating clearly the extent of the risk involved. Changing the discourse would involve reporting risks positively in general conversations on the labour ward and in national guidelines, such as those from the National Institute for Health and Care Excellence. The positive re-framing of the 0.5 to two percent risk of uterine rupture during vaginal birth following caesarean section (VBAC) as a ninety-eight percent risk that the uterus will not rupture following VBAC is an example of the positive re-framing of risk that I suggest.
- Acknowledging the primacy of women, the worth of midwifery knowledge and the benefits of normalising care for all women and the danger of unnecessary medical intervention within national and local policy statements should recognise the contribution of midwives who practise on the labour ward and improve care for women.

- Ensuring, as far as is possible, that labour wards are staffed with an appropriate number of midwives to give one-to-one care to women will contribute to a reduction of stress and fear in midwives; it should also make coordinating work easier for the LWC. Providing one midwife to care for one woman, as I suggested earlier (p.222), should reduce women's need for medical intervention. The development of social capital within labour wards should be encouraged as it is capable of reducing staff sickness and will prevent low staffing levels despite having a full complement of midwifery staff.
- The return to a pattern of shorter shift working, although more expensive, is likely to prevent stress and burn out. In the long-term shorter shifts should prove more cost- effective as they have the potential to prevent ill health, enhance the quality of care provision and reduce litigation as a consequence.

The strategies I suggest imply some investment and expenditure. However, the strategies could enhance effective decision-making, improve the quality of care that team working is associated with (Thomas and Dixon 2012, Knight et al. 2014) and improve maternal satisfaction. The prospect is that the strategies would pay for themselves through a reduction in litigation in the maternity services that is currently higher than any other service in the NHS (NHS Litigation Authority 2014).

Recommendations for Practice

If clinical leadership is to be developed changes to the context of practice are requisite.

Reducing Fear and Risk

- Including the woman, midwife and obstetrician in the assessment of risk should lead to the recognition of clinical risk, based not only on physical

factors but also on holistic psychological and environmental factors. Sharing responsibility for decision-making between the woman, midwife and obstetrician with regard to risk assessment on the labour ward has the potential to reduce the fear of litigation and blame for health professionals and empower the woman to take control of her birth.

- Raising awareness of the positive outcomes of care on labour wards amongst clinicians, such as giving precedence to the number of vaginal births during multi-professional ward meetings rather than concentrating upon the caesarean rate would produce a positive rather than negative perspective on care giving.

Developing Social Capital and Values-Based Practice

- Employing LWCs who are capable of role-modelling 'softer', values-based care, by valuing others, being respectful, approachable, teaching and empowering others would probably influence other midwives to practise in the same way. Consideration of the use of effective educational and recruitment strategies would be required to both develop and attract midwives with the appropriate characteristics. Providing opportunities for would-be LWCs, such as the 'acting' LWC position or the 'Wing Man' is likely to facilitate the acquisition of clinical and personal skills required to become an effective clinical leader on labour ward.
- Developing an organisational philosophy to support working in a respectful and collegial, client-centred manner, that is re-enforced at regular intervals as part of institutional updates, should be the responsibility of all NHS Trusts to enhance institutional social capital. Making it the responsibility of every person in the organisation to uphold the philosophy and being intolerant of and being able to challenge poor or bullying behaviour in any form can also facilitate the development of the 'virtuous circle'. Treating others with respect

and being treated with respect should influence clinicians to give care in the same way.

Support for Clinical Leaders

Enhanced support for the LWC is implicated to prevent the severity of the emotional and physical stress they experienced due to their enhanced responsibility and lack of managerial support.

- Clinical supervision is implicated as part of the mandatory training of midwives that would facilitate midwives to reflect on their practice. The allocation of a 'Wing Man' on each shift would facilitate both the coordination of the workload and support for practical midwifery care.
- Creating posts for full-time labour ward managers and arranging regular meetings with, or visits to the labour ward by the midwifery matron, consultant midwife or HOM is likely to reassure the LWCs that they are not alone. This contact would facilitate their ability to escalate their concerns and ideas to someone who has some strategic influence to deal with them. The appointment and support of visible, research active, practice development or consultant midwives would contribute to the LWCs' and other midwives' insight into 'best' practice to develop effective, shared decision making with women.

Facilitating Collaborative Practice

Facilitating opportunities for midwives, obstetricians, anaesthetists and other members of the multidisciplinary team to work closely together during each shift has the potential to facilitate professional support, power-sharing, development of social capital between the professions and to enhance a sense of camaraderie and respect. Strategies, such as:

- Involving both midwives and obstetricians in the development of guidelines that reflect both a midwifery and obstetric approach to care giving would facilitate midwifery practice and prevent obstetricians being kept away from the labour ward.
- Ensuring the attendance of midwives during shift time to attend multidisciplinary forums could lead to shared learning and contribute to developments in woman-centred practice.
- Multi-professional clinical supervision is capable of facilitating diverse ways of practice and thinking (Deery 2005) and lead to a recognition of the importance of different ways of knowing and doing within care giving. If all midwives feel supported and valued they are likely to be less reliant upon heroic clinical leaders. The need for clinical leaders to be controlling, formidable groups that inhibit change would subsequently be reduced.

Recommendations for Education

Clinical Leadership Preparation

- Clinical leadership preparation courses for LWCs are implicated in addition to learning the enhanced clinical skills required of clinical leaders through their experience of being a 'Wing Man' if clinical leadership is to develop and be fit for purpose. Formal preparation would avoid the socialisation of professional midwifery practice and clinical leadership; it would prevent the perpetuation of particular practises, as well as ways of leading that are outdated and that become difficult to change or innovate.
- Engaging consultant midwives and lead midwives for education (LME) to conduct research and produce clinical leadership preparation packages relevant for local requirements would facilitate hospital trusts and higher education institutions to work alongside one another. These partnerships

have the potential to enhance clinical leadership practice and develop knowledge. Incorporating the examination of professional values into the development of clinical leaders and in the pre-registration education of midwives is important. Raising the awareness of midwifery values would raise the profile of midwifery and its contribution to care; it would also facilitate the success of future clinical leaders in midwifery.

- Clarifying the meaning attached to clinical leadership locally and raising an awareness of the potential impact on practice would facilitate understanding and stimulate an interest in the development of a new generation of effective clinical leaders on the labour ward. Workshops within mandatory training days conducted by local lecturers and clinical leadership clinicians can introduce the concept of clinical leadership and identify those midwives who are interested in developing the relevant clinical leadership skills in the future.
- Introducing student midwives, doctors and midwives to the concept of clinical leadership in both undergraduate and postgraduate curricula and appointing and naming midwives and obstetricians as 'clinical leaders' also facilitate a growing awareness of the aims and potential of clinical leadership. Introducing pre-registration midwives and doctors to clinical supervision would more adequately prepare them for the tensions within clinical practice at registration and lead them to demand the same support of their employers.

Inter-professional Education

Facilitating midwives and obstetricians to work and learn together during their formative development has the capability of developing collaborative practice and prevent them from practising in silos in the future. The English National Maternity Review (2016) advocates that midwives and obstetricians are educated together at both pre and post registration to develop early working relationships and an understanding of one another's practice. The NHS has received two million

pounds for multi-professional training from April 2016 to develop training skills in approximately 5 percent of all health professionals. These clinicians will become involved in local multi professional teams to deliver training to all local teams in a multi-professional setting. Finances are therefore in place to facilitate this.

Recommendations for Future Research

- Further research into clinical leadership on the labour ward to represent the perspective of the obstetrician will facilitate a broader insight into their clinical leadership, relationships with midwives, explore the perception that obstetricians intervene if called to labour ward and the decision making involved in the use of unnecessary medical intervention that drove the LWCs to keep them away.
- Employing Bourdieu's Theory of Practice to examine clinical leadership in other acute practice environments similar to the labour ward, such as accident emergency or medicine, should clarify whether heroic forms of clinical leadership are prevalent in these types of areas.
- Emotion work has been acknowledged in the midwifery literature however, this study uncovered a secondary finding that suggests there is also a physical impact of practice on the well-being of midwives that is worthy of future inquiry.
- Finding a potential benefit in power-over relationships suggests it requires further investigation.
- Increasing the amount of research related to clinical leadership in midwifery will raise awareness about clinical leadership amongst the midwives to facilitate discussion and its future development. Action research would be a means of developing relationships between obstetricians and midwives, shared leadership and a more woman focused approach to care giving.

Dissemination

The findings of this study will be of significance to those who are responsible for the commissioning, strategic management and development of maternity services in the UK, such as commissioners, heads of midwifery, midwifery matrons, consultant midwives, obstetricians and practising midwives in all areas. Clinical leaders will see relevance in the findings for their practice and therefore the study has the potential to directly influence clinical care. The research will contribute to and support the current clinical leadership literature. In addition to this, Bourdieu's theory of practice, as a lens through which to analyse critical ethnography, will be of interest to researchers and social science theorists.

Raising awareness of the social hierarchy and the potential for class and gendered relationships amongst midwives and obstetricians and discussing the impact of these upon person-centred practice in undergraduate, inter-professional preparation will be a first step to acknowledging and changing this. The findings of the study will be disseminated through conference presentations and publications in journals that will reach different groups and health professionals, such as British Medical Journal online, Midwifery and The Sociology of Health and Illness.

Conclusion

This research explored clinical leadership on two NHS labour wards in the North of England using a critical ethnographic methodology. Recommendations have been made for policy, practice, education and future research that address the findings.

A socialised, heroic style of clinical leadership that prioritised safety over innovation was practised by the LWCs in the busy, unpredictable, scary labour ward environment. However, effective clinical leadership was also characterised by transformational, values-based leadership that helped midwives to cope with their heavy, stressful workload. Although the LWCs employed a combination of heroic and

congruent leadership, the contradictory nature of their position led them to experience emotional and physical stress.

Whilst the possession of positional power facilitated the LWC to co-ordinate care, the accountability inherent in their position meant that the LWCs were vulnerable to being blamed. Whilst many LWCs facilitated the decision-making of other midwives, because the buck stopped with them, they often had to have the final say. The organisational structure that attributed the LWCs with the greatest degree of accountability represents a system failure that does not facilitate autonomous midwifery practice which ironically extends the already significant responsibility of the LWC and leads to an inability to contribute to change or to improve midwifery practice.

The increasingly high-risk labour ward environment resulted in the balance of power resting with the obstetricians. The subsequent loss of recognition of the midwifery contribution to care and the discrimination experienced led to risk-taking and dysfunctional relationships in a battle to practise midwifery. Unless changes are made to the model of care that existed in this study; that required accountability to be invested in the LWC clinical leader, that was predicated on fear and risk, where the work is relentless, where clinical leadership development was socialised and unequal power relationships and discrimination existed, a democratic, creative, innovative style of clinical leadership that leads to innovation and improvements in care cannot be practised.

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Appendix 1: Leadership Theories

Leadership Theories		
Biological-Genetic	Great-Man	Belief that leaders are born rather than made and were able to change history and heroically save the day.
	Warrior	These types of leaders are required to win wars and may need to be ruthless in pursuit of this.
Trait		Leadership theories were founded on the particular mental, physical and social qualities of leaders until the 1940s and is still prevalent currently.
Behavioural		Relates to the leaders' behaviour and suggests leaders/leadership can be made/taught.
Situational/contingency		These theories oppose trait theories as they suggest the situation or context determines which leaders will emerge.
	Person-Situational	Suggests that when a crisis occurs situation may not be sufficient to determine which leaders will emerge. It has to be a combination of the situation and the attributes of a potential leader that determines whether they are able to cope with the crisis that exists.
Transactional		Relates to the transactions made between the leader and her/his followers. This type of leadership is associated with task based management and with reward and punishment to incentivise her/his follower.
Transformational		This relates to charismatic leadership. Leaders who have a positive transformational effect on their followers motivate them to follow their vision.

Adapted from Bass (2008).

Appendix 2: Literature Review Methods

I began this thesis intending to examine midwifery leadership on the labour ward and therefore a review to synthesise and critically evaluate the literature was undertaken to provide a background and rationale for the research. I realise that owing to the dearth of research literature retrieved with regard to midwifery leadership the option may have been to examine 'nursing leadership' literature. However, whilst reviewing the leadership literature, 'clinical' leadership appeared to be a term that represented the type of leadership that could be most appropriately applied to leadership on labour ward. A subsequent review of the literature review was therefore undertaken to explore clinical leadership. The critical analysis of the literature retrieved from both reviews, as well as the objectives of the research facilitated the structure of chapters two and three.

Literature Searches

Searches were conducted on three occasions during the study in 2011, January/February 2015 and completed in February 2016. The searches varied in their focus in response to the themes observed within the data. The intention was to ensure that all the relevant and up-to-date literature was included in the study. A wide range of databases associated with the health care literature were searched (see table below). A pragmatic decision was made not to search management databases to ensure that it was a manageable process and within the scope of this work. Citation tracking facilitated the identification of book chapters and grey literature. The searching of key journals was also undertaken. During the review of the clinical leadership literature an author was contacted to locate further literature.

List of databases

Databases
CINAHL, Cochrane, PSYCHinfo, PubMed (Medline), Science Direct, Evidence Search (Health Info Resource), Intute, Web of Science Emerald Journals, MAG online (Intermid/Internurse), TRIP, Scopus

Multiple terms were employed for both reviews using Boolean operators and in several combinations to retrieve the relevant literature. No other parameters on publication, such as date or language were applied in the expectation that no relevant data would be missed, although this resulted in the examination of a large amount of literature.

Key Terms for Midwifery Leadership on labour ward search

Key Terms
Leader* OR manage*
labour ward* OR delivery suite* OR labour suite OR midwi* OR matern*
health service* OR NHS OR public sector OR public service*
G Grade midwife OR band 7 midwife OR labour ward coordinat* OR shift lead*

Key Terms for Clinical Leadership Review

Key Terms
“clinical leader*” OR clinical leader* OR front line leader* OR distributed leader* OR democratic leader* OR bedside leader*
nurs* OR midwi* OR NHS OR health care

The literature was searched for the presence of the key terms in the title or abstract using broad inclusion criteria. All citations were saved in an Endnote library. The retrieval and reading of the relevant literature led to the selection of literature to be included in or removed from the review. I acknowledge that the lack of consensus on

the labelling of 'clinical leadership' may have prevented the identification of relevant literature. To compensate for this, literature was read that I perceived related to clinical leadership, such as 'distributed' leadership. Whilst the reviews located empirical studies, they also uncovered policy documents, literature reviews and opinion that facilitated the critical thinking in chapters two and three.

Data extraction was undertaken using a form for each review (see Appendices 3 and 4). A CASP tool was employed as a means of critical appraisal. I employed quality appraisal to support a critical review of the literature and to facilitate the development of themes, rather than to solely determine quality. Walsh and Downe (2006) suggest that contention exists with regard to the appraisal of qualitative research, the use of criteria, the type of criteria and how it is used.

'A checklist is indicative of quality but does not guarantee it'
(Walsh and Downe 2006 p.117)

As qualitative research is a diverse field, a generic set of criteria may not apply to all. Cohen and Crabtree (2008) recommend that evaluation is also sensitive to the theoretical and methodological framework from which it emerges. Two empirical studies were located with regard to midwifery leadership. Neither study addressed midwifery leadership on the labour ward. One study was retrieved with regard to clinical leadership and midwifery. The decision was made to critically consider the three pieces of literature together in chapter two, along with the relevant policy and opinion. Whilst the literature retrieved relating to clinical leadership in nursing, the surrounding policy and opinion comprised the structure of chapter three.

Appendix 3: Summary Table and Data Extraction of Midwifery Leadership Literature

Author(s)	Year	Location and focus of Study	Study Design and analysis	Sample	Summary of relevant findings
Byrom & Downe (2010)	2010	North West England Two maternity departments To explore midwives accounts of 'good' leadership/midwifery	Phenomenological Interview Survey- positive stance (appreciative in nature) Interviews: 3 open ended questions. 60 minutes long Thematic analysis- manual both authors and an assistant	10 midwives, various pay banding/status from antenatal/postnatal/labour ward and community. Cross sectional representation. Allocated by manager	Skilled competence – ability to act safely and competently basic requirement for clinical midwives and midwifery leaders. Emotional intelligence – what made midwifery leaders good was the extent of their emotional capability.
Divall	2015	Midlands, England. To explore midwifery leaders' narratives of identity.	Exploratory case study Observation and Interview Thematic analysis.	9 midwifery leaders. 7 Matrons and 1 educationalist who attended a leadership course	Identification of themselves as midwives challenged within professional group and organisation. Required support from professional group and organisation to maintain positive self and social identity
Kay (2010)	2010	NHS Community England. To critically examine community team leaders' perceptions that the autonomy of midwives in team being a challenge and highlight need for a local leadership development programme	Critical Ethnography. Interviews & non-participant observation. Domain, taxonomic and componential analysis & search for cultural themes.	5 of 12 midwifery team leaders. Four Maternity Teams 2 of the 4 team meetings observed.	Need to; Define leadership role and its' remit. Develop person in role. Have time and space to meet requirements of role. Develop career pathway to team leadership role

Appendix 4: Summary Table and Data Extraction of UK Clinical Leadership Literature

Author(s)	Year	Location and focus of Study	Study Design and analysis	Sample	Summary of relevant findings	Limitations
Bousefield (Clinical Nurse Specialist)	1997	England To investigate how a group of clinical nurse specialists think and experience role	Phenomenology-bracketed Semi-structured (S-S) Interviews- open ended Constituent analysis	Purposive 7/20 CNSs- H Grade – registered nurses (2 dual trained- sick children's nurse and midwife) - female 1 hospital	Enthusiastic regarding leadership role. Clinical competence important Majority unsupported and disempowered by organisation, peers and doctors. Isolated. Pressure to define role and conflict with dominant medical profession. Experienced burn out. Organisational structures get in way of practice	
Burns (General Practice Nurses)	2009 a,b,c	England To explore the concept of clinical leadership from a practice nurse's perspective. a) perceived needs b) facilitating factors	Phenomenology S-S interviews Colaizzi- thematic analysis	Purposive 12 practice nurses. 1 Primary Care Trust. 6 employed by a GP and 6 by Primary Care Trust.	a) Described clinical leader as 'being there'- available for support and advice. Need to be clinically competent, approachable, listen, emotionally intelligent, have status. Were isolated b) Facilitating factors-development-control of workload-confidence-drive-environ impacted on ability to lead-power of GP and being employed – org environ important for effective clinical leadership. lack of power at strategic level c) Leadership mechanisms existed in absence of official clinical leadership structures-lack of leader role model-peer support-used guidelines- saw GP as clinical leader. Require recognised clinical lead and skills training	

<p>Carney (Public Health Nurses - specialist nurses)</p>	<p>2009</p>	<p>Ireland</p> <p>To identify how clinical leadership skills are perceived by public health nurses and effectiveness and consequence of skills in primary care delivery</p>	<p>Qualitative</p> <p>Narrative interviews Narrative analyses</p>	<p>Purposive.</p> <p>20 public health nurses attending professional development programme</p>	<p>Clinical leaders seen as collaborators: facilitate good practice; mentor; decision makers through evidence based practice. Leadership principles; building and directing team/good relations; interest in practice and development; competence and motivated. Why problems arise: autocratic management; poor communication; lack of vision or unrealistic. Lack of empowerment experienced, silenced; require empowerment and access to conflict resolution skills</p>	
<p>Carryer, Gardner, Dunn & Gardner (Nurse practitioner Specialist)</p>	<p>2007</p>	<p>Australia and New Zealand</p> <p>To illustrate the core role of the nurse practitioner in Australia and New Zealand</p>	<p>Interpretive S-S interviews and data sources</p> <p>Thematic analysis</p>	<p>Purposive</p> <p>15 nurse practitioners 1:3 from New Zealand</p>	<p>Core role revolved around 3 components; Dynamic practice- clinical expertise at core – extended roles Professional efficacy-autonomy and accountability Clinical leadership- led and developed practice- responsible for practice of others. Emerging role.</p>	

<p>Christian & Norman (Manager/CL)</p>	<p>1998</p>	<p>England</p> <p>To describe personal and professional characteristics of Clinical leaders in Nursing Development Units (NDUs)</p>	<p>Mixed methods</p> <p>4 phases- findings from 2nd phase- questionnaire and interviews S-S interview Survey case study,</p> <p>comparisons, profiling Thematic, descriptive statistics.</p>	<p>28 NDUs 49 CLs 31 questionnaires of 25 returned (20 from women) 28 interviews</p>	<p>Characteristics 10 elements central to role applicable to other settings Coordination- dissemination – networking- encourage staff ownership- advising and expertise-enabling development – change agent- managing change-supporting staff- managing finances Position of clinical leader in organisational hierarchy crucial to her/his ability to act on responsibility and fulfil role.</p>	
<p>Connelly, Yoder & Miner-Williams (Charge Nurse)</p>	<p>2003</p>	<p>America- Military</p> <p>To identify charge nurse competencies</p>	<p>Qualitative</p> <p>Interviews-42</p> <p>Descriptive analysis-constant comparison- for similarities and differences</p>	<p>Stratified purposive</p> <p>33 females, 9 males. 11 -staff, head nurses -10, charge nurses -12, supervisory nurses - 9</p>	<p>54 competencies. 4 categories; Clinical/technical. Critical thinking. Organisational. Human relations skills Is an administrator-directs activities-responsible for efforts of others. Saw as a front line manager 15 characteristics- Accountability, assertiveness, positive attitude, authority, fair, confidence, need to control, humour, flexibility, image, initiative, maturity, able to learn from mistakes, command respect, responsible.</p>	

<p>Cook (Specialist nurses)</p>	<p>2001a</p>	<p>England</p> <p>To identify attributes of effective clinical nurse leader</p>	<p>Grounded theory</p> <p>S-S interviews and observation</p> <p>Coding- grounded theory</p>	<p>Purposive</p> <p>4 nurses- represented- hospital based nursing, community adult nursing, sexual health nursing, family mental health nursing -gave clinical care and leadership responsibility</p>	<p>5 attributes-highlighting, respecting, influencing, creativity and supporting</p> <p>5 typologies- discoverer, valuer, enabler, shaper, modifier. Constraints and facilitating factors apparent relating to empowerment/engagement and control/lack of engagement.</p>	
<p>Donnelly (Advanced practice nurses-specialists)</p>	<p>2005</p>	<p>Canadian Doctoral thesis</p> <p>To explore lived experience of advanced nurse practitioners in clinical context to provide holistic patient care.</p>	<p>Phenomenology</p> <p>Open ended interviews</p> <p>Discovery oriented approach and theme generation.</p>	<p>Purposive</p> <p>8 advanced practitioners advanced nurse practitioners (ANPs) and clinical nurse specialists (CNS)</p>	<p>Role to:</p> <p>Develop nursing practice, clinical experience important, able to use clinical judgement and reasoning</p> <p>Blend nursing and medicine- preserve caring- provides holism</p> <p>Advocacy for individual patients</p> <p>Embrace research</p> <p>Have power</p> <p>Themes- leading development of practice, grounding practice in values- using evidence to guide practice.</p>	

<p>Elliott, Higgins. Begley, Lalor, Sheerin, Coyne & Murphy</p> <p>(Specialist Nurses)</p>	<p>2012</p>	<p>Ireland</p> <p>To identify how leadership is enacted by advanced practitioners- clinical specialists and advanced practitioners</p>	<p>Case study- national</p> <p>Observation, interviews, policies</p> <p>Analytical framework analysis</p>	<p>Purposive</p> <p>N = 23 6 APs and 17 CSs</p> <p>Nurses and midwives-</p>	<p><i>7 clinical leadership activities: Coordination, initiates change, responsible for guidelines, develops services, educates MDT, mentors, role model</i></p> <p><i>2 professional leadership activities: develops policy at a (inter)national levels, education outside service, involved in professional organisations.</i></p>	<p>Short observation time-may not have reached saturation.</p>
<p>Ennis, Happell & Reid-Searl</p> <p>(Characteristics)</p>	<p>2013</p>	<p>Australian</p> <p>To explore the attributes required for effective clinical leadership in mental health nursing, especially communication.</p>	<p>Grounded theory</p> <p>Interviews</p> <p>Grounded theory analysis</p>	<p>Purposive</p> <p>1 mental health service in Victoria</p> <p>12 mental health nurses- not clinical leaders</p>	<p><i>Communication important to clinical leaders work</i></p> <p><i>Able to adjust to circumstances</i></p> <p><i>Good non-verbal skills- listens- self-aware- builds up rapport with staff and patients- open and honest- understandable.</i></p>	

<p>Franks & Howarth (Nurse Consultant)</p>	2012	<p>England</p> <p>To establish key attributes of nurse consultants specialising in safeguarding</p>	<p>Qualitative/quantitative</p> <p>Diaries Coded activities S-S interviews</p> <p>Thematic analysis and SWOT</p>	<p>Purposive</p> <p>4 Consultant nurses from different sites 6 stakeholders</p>	<p>Activities: clinical 24%, education 16%, leadership 41%, quality assurance/research 11%. Other 8%. Strengths- not managers or clinicians- influence Weaknesses- lack of support/ power, development- not understood Opportunities- raise profile of safeguarding Threats- competing priorities</p>	<p>1 sample of branch of nurse consultants in England.</p>
<p>Gould (Matron)</p>	2008	<p>England</p> <p>To describe how matrons in an acute NHS trust perceive and undertake role</p>	<p>Qualitative</p> <p>S-S interviews</p> <p>Thematic analysis</p>	<p>22 matrons 1 NHS trust</p>	<p>Differences in way performed role. Promoted clinical leadership, maintained high clinical profile. Problems promoting cleanliness.</p>	
<p>Manley, Webster, Hale, Hayes & Minardi (Consultant Nurse)</p>	2008	<p>England</p> <p>To explore how the leadership component of the consultant nurse was reflected in day to day working.</p>	<p>Cooperative inquiry</p> <p>Action research based Reflection and story writing</p> <p>Phenomenological analysis</p>	<p>Authors of article- all consultant nurses- (n =5) for elderly in acute services</p>	<p>Prerequisites for CN; clinical expertise/ credibility/ clarity of role, modelled expertise and enabled expertise in others. 2 themes- complexity and pathway. Impact pt, staff and organisation. Described triggers, such as inability of staff to cope with complex issues and enabling factors for leadership strategies at clinical and organisational level. Worked across boundaries. Need support to make contribution visible, well placed at clinical and organisational level to influence care.</p>	<p>Authors also participants.</p>

<p>Mannix, Wilkes & Daly (Characteristics)</p>	2015	<p>Australia</p> <p>To determine nurses' perceptions of aesthetic leadership among clinical leaders in nursing</p>	<p>Mixed method. Online descriptive survey</p> <p>SPSS and framework analysis</p>	<p>Convenience sample of nurses. through Twitter, Facebook and e learning platforms 66 survey responses 31 written accounts</p>	<p>Most valued aesthetic characteristics were; Support, communication, and approach. Less likely to take risks and be challenging. May positively impact workplace and create calm, positive work place.</p>	<p>Risk taking findings- could have examined gender of clinical nurse leader</p>
<p>Marshall, Spiby & McCormick</p>	2014	<p>English</p> <p>Evaluation of 'Focus on Normal Birth and Reducing Caesarean section Rates Rapid Improvement Programme'</p>	<p>Mixed methods</p> <p>Mode of birth data Questionnaires Interviews</p> <p>Summary statistics and content analysis Thematic analysis</p>	<p>20 NHS trusts that participated in the programme. 54 Questionnaires to health care professionals, 11 to service user reps, g 4 key individuals in each trust Interviews with 5 key individuals in 6 of trusts that represented the trusts as a whole.</p>	<p>Reduced caesarean section rates in 8 trusts. Features associated with low rates were: shared philosophy prioritising normal birth, clear interdisciplinary communication, strong leadership at a range of levels- executive support and clinical leaders in each discipline. Important that philosophy and context of care examined to identify facilitating factors and barriers</p>	<p>Not directly related to clinical leadership. However identified clinical leadership as an important factor in lowering caesarean section rates. Difficulty obtaining data- that was variable from trusts. Time constraints prevented sequential evaluation.</p>

<p>Martin & Waring (Team Leaders- Ward Sister)</p>	2012	<p>England</p> <p>To explore the experiences of newly designated team leaders and theatre coordinators</p>	<p>S-S interviews</p> <p>Coding and thematic analysis</p>	<p>Purposive</p> <p>20 theatres, 2 sites 12 team leaders 11 theatre coordinators</p>	<p>Limited to enact roles Professional and managerial hierarchies constrained leadership- problem if leadership to be devolved in response to drivers. Changes in organisational, professional and institutional contexts required</p>	
<p>Matthew-Maich, Ploeg, Jack & Dobbins (Specialist Nurses-Lactation Consultants)</p>	2012	<p>Canada</p> <p>To explore the process and strategies used by front line leaders to support the uptake of the Breastfeeding Best Practice Guideline.</p>	<p>Constructivist grounded theory</p> <p>Observation interviews and documents coding</p>	<p>3 hospitals Purposive criterion based and snowball 58 health professionals 54 clients</p>	<p>Front line leaders make it happen Who are passionate, persistent and respected. Individual beliefs, organisational, inter-organisational and inter-professional partnerships important to uptake.</p>	
<p>Mayo, Agocs-Scott, Khaghani, Meckes, Moti, Redeemer, Voorhees, Gravell & Cuenca (Specialist Practice)</p>	2010	<p>America</p> <p>To describe clinical nurse specialist practice patterns</p>	<p>Survey CNS Activity questionnaire</p> <p>Outcomes and barriers analysis survey and demographic survey SPSS V. 11.5</p>	<p>947 CNSs responded (n = 1,523) 62.1%</p>	<p>5 top activities: attend meetings-consult with other disciplines- teach staff- support staff- evaluate treatment. Most active in consulting and leadership 5 top barriers: multiple job expectations (no 1 barrier); lack of time; lack of secretarial support. Do not reflect CNS job description- may need to change. Most of time spent on clinical practice.</p>	

<p>Mcnamara, Fealy, Casey et al (Characteristics)</p>	2011	<p>Ireland</p> <p>To describe Irish Nurse's views of clinical leadership and development needs</p>	<p>Qualitative</p> <p>Focus groups</p> <p>Conceptual framework analysis</p>	<p>144 nurses from 13 practice settings – 4 regions</p> <p>17 focus group</p>	<p>4 critical leader roles and functions; contribution to care/ representing nursing (foundational); effective teamwork; challenging; changing and innovation and conflict resolution. Ways nurses contribute to care- maintain safety, dignity, advocacy, coordinating care and compensatory action.</p>	<p>New research instrument for survey. May need further refinement. Confined to nurses in public sector, may not represent those in private sector.</p>
<p>Mitchell, Butler-Williams, Easton, Ingledeu, Parkin, Wade & Warner (Nurse Consultant)</p>	2010	<p>England</p> <p>To explain diversity and complexity of Consultant nurse role in an NHS Trust and describe practice and difference to other advanced practice roles</p>	<p>Qualitative, interpretive approach- identify attributes of practice Written accounts of practice- role audit Concept mapping analysis</p>	<p>Purposive sample- 6 Consultant Nurses- 1 trust Critical care outreach, gynaecology, oncology, orthopaedics, vascular surgery and neurology</p>	<p>Themes to represent role- entrepreneurial activity, clinical activity, role dynamism, national and international research conduct, consultancy and education across boundaries</p>	<p>Not all achieved all themes</p>

<p>Redwood, Lloyd, Carr, Hancock, McSherry, Campbell & Graham</p> <p>(Consultant Nurse)</p>	2006	<p>England</p> <p>To evaluate the work of nurse consultants in the NHS by exploring key informants and nurse consultants</p>	<p>Qualitative 360 degree feedback</p> <p>S-S interviews</p> <p>Thematic content analysis</p>	<p>14 nurse consultants from multiple sites</p> <p>10 key informants each-interviewed. Selected by By NC- may have been over positive.</p>	<p>Themes: role aspirations, lived reality, challenging boundaries, impact and outcomes and leadership. Nurse consultant impact is in leadership, clinical expertise, research and educational activity.</p>	<p>Conducted in 2nd and 3rd year of implementation of role and therefore early to evaluate. Participatory nature of study may make findings less generaliseable to other areas. Omitted some data that may have identified participants.</p>
<p>Roberts, Floyd & Thompson</p> <p>(Clinical Nurse Specialist)</p>	2011	<p>New Zealand</p> <p>To investigate the role of the clinical nurse specialist (CNS)</p>	<p>Descriptive, exploratory study</p> <p>Examination of documents and job descriptions</p> <p>Quantitative and qualitative analysis – descriptive statistics and thematic analysis</p>	<p>Human resource departments of 8 District Health Boards in New Zealand- range of regional and tertiary sites.</p> <p>32 documents- 15 analysed.</p>	<p>Few areas of consensus regarding essential requirements of role. Inconsistencies of definition. Described as leader, clinical expert, coordinator and educator</p>	

<p>Royal College of Nursing (RCN) (Ward Sister)</p>	2009	<p>England</p> <p>To explore role of ward sister, its' contemporary situation and context</p>	<p>Qualitative</p> <p>6 focus groups not clear how evaluated</p>	<p>Purposive</p> <p>6 focus groups , different hospitals</p> <p>90 ward sisters-</p>	<p>Complex role but agreed lead nursing to facilitate safe, quality care. Expertise, leader-standards, support, supervise, risk assess, communicator, educator, manager, researcher. BUT diff to be visible-heavy work load, diverse remit-pay poor not valued, lacked real authority to change. Little preparation and lack of support.</p>	<p>Unclear of mix of sample and how data analysed.</p>
<p>Royal College of Nursing Institute & The University of Sheffield (Matron)</p>	2004	<p>England</p> <p>To evaluate the role of the Modern Matron</p>	<p>Mixed Methods</p> <p>Survey Case study S-S interviews Themes and statistics</p>	<p>545 questionnaires response (73% n = 414)</p> <p>10 case studies in 6 NHS Trusts</p> <p>Questionnaire to all Directors of Nursing in all NHS Trusts</p> <p>Questionnaires to all matrons in 10 trusts (n = 176) 69% response (n = 121)</p>	<p>Main areas identified re: experiences of matrons; role conflict and tensions, lack of clarity/shared understandings of role, fragile sense of authority, competing priorities, role overload, leadership role, inequitable grading and responsibilities</p>	
<p>Spiby, Green, Richardson & Hucknall</p>	2013	<p>England</p> <p>To identify the changes to early labour services, their triggers and monitoring</p>	<p>Mixed methods</p> <p>Survey S-S interviews</p>	<p>Purposive</p> <p>145 NHS trusts (89%) questionnaires</p> <p>17 heads of midwifery or designated senior midwives interviewed.</p>	<p>83 units made changes to early labour services. Impact of admissions on workload a trigger for change. Experiences of introducing change; issues re engaging staff and contribution of clinical leadership.</p>	<p>Research did not set out to examine clinical leadership in midwifery. The findings suggest it is warranted to facilitate change management.</p>

<p>Stanley (Characteristics)</p>	2006	<p>England</p> <p>To identify who clinical leaders are and critically analyse experience of being a clinical leader.</p>	<p>Grounded theory</p> <p>Mixed methods Survey Interviews</p> <p>Grounded theory approach to analysis.</p>	<p>Questionnaires (n=830) 188 returned (22.6%) 42 S-S interviews staff of 36 different areas- 4 clinical areas 2 S-S interviews with clinical leaders from each area- 8 in total 5% male, 95% female</p>	<p>Clinical leaders seen as experts in their field, approachable, effective communicators, empowered to act as a role model, motivate others through matching values and beliefs with practice. Congruent leadership theory espoused.</p>	<p>Low return of survey data</p>
<p>Stanley (Characteristics)</p>	2014	<p>Australia</p> <p>To identify how clinical leadership was perceived by paramedics in their everyday work</p>	<p>Phenomenology</p> <p>Questionnaire</p> <p>SPSS Manual data configuration</p>	<p>Questionnaire (n= 250) 104 (41.6%)</p>	<p>Being controlling, artistic, imaginative, administrator- least associated with clinical leadership. Similarities to findings in 2004 study Clinical leaders have values and beliefs on display, rather than vision. Different to other leaders.</p>	<p>Volunteer ambulance staff not accessed</p>

<p>Storey & Holti (Implementation)</p>	<p>2013</p>	<p>England- London and Manchester</p> <p>To gain insight into cross boundary service redesigns. What could be learned from experience of implementing clinical leadership in practice? What were the enablers and constraining factors? Clinical leadership in clinicians of all types in the areas concerned.</p>	<p>Qualitative. Case study sites</p> <p>Observation and interview. 4 way comparison of meetings and interviews</p> <p>Coding and thematic analysis.</p>	<p>4 case sites across the two areas. Multiple institutions within primary, acute trusts, independent and voluntary sectors. Different power dimensions in the two. 74 participants. Dementia and sexual health. Hospital consultants, junior doctors, nurses, managers, commissioners care assistants, psychologists</p>	<p>Many obstacles to clinical leadership; Despite obstacles service design possible Found at multiple levels- role of clinicians shaping policy not underestimated. Require legitimacy- national drivers- or funding. Requires skilful practice- especially collaboration. Capable of being open to new ideas Implementation leadership important Leadership and formal project planning need to work in tandem to be successful. Need focus on service user needs, Informal cross boundary relationships important- frustrated by compartmentalised NHS. Networking organisations imp. National strategies empower clinicians to go forward.</p>	
<p>Wickham (Specialists)</p>	<p>2013</p>	<p>Ireland To explore the clinical nurse and midwife specialist roles in practice</p>	<p>Quantitative methodology Survey SPSS</p>	<p>Total population of CNS/CMS 1486 (n=744) Response 51%</p>	<p>Active in role of researcher, educator, communicator, change agent, leader and clinical specialist. Varies between roles and role elements. Potential positive effect on care.</p>	

Appendix 5: General Research Information Sheet

General Research Information Sheet

This information is related to a research study with regard to clinical leadership in midwifery that will take place on the labour ward.

Clinical Leadership on the Labour Ward

Midwives who practice on the labour ward on two different sites are being invited to participate in a study to explore their perceptions of clinical leadership. The research aims to examine the characteristics of midwifery clinical leaders on the labour ward and find out whether philosophies of care or service provision have an impact upon these.

Who is organising the study?

My name is Julie Parkin and I am a midwifery lecturer working and studying for a PhD at the University of Huddersfield. I am supervised by Dr Joyce Marshall (University of Huddersfield), Professor Ruth Deery (University of West Scotland) and Dr Pamela Fisher (University of Liverpool).

Why is the research being done?

Leadership is seen as being very important in the NHS today as it is related to helping services to change and develop. Clinical leaders are amongst those clinicians who deliver care on the front line of services and have a direct affect upon them. Increased understanding of the nature of clinical leadership on the labour ward has the potential to assist in the future development of effective clinical leaders that will be of benefit to both women and clinicians working in this area.

How will I be involved in this study?

Due to your role you will probably be working on the labour ward whilst I am making observations. I will be observing midwifery activity on the labour ward and if you are involved in this it may be noted. I will visit the area regularly prior to commencement of the study so that there will be an opportunity to meet and ask questions. An observation schedule will be made available to labour ward staff and this will be adhered to as closely as possible. Observations will be made over a 2 month period and will last for approximately 2 hours each time. No video/DVD recordings will be made.

Will the information I give be kept confidential?

All information that is collected about you during the study will be kept strictly confidential. I will not keep your name with anything that has been observed or said, nor will I feed back any comments to anyone. No one who has taken part in the research will be identified in the reports or publications. Ethical approval has been granted from the University of Huddersfield, School of Human Health Sciences Research Ethics Committee in line with the 'Clinical Leadership on the labour Ward' recommendations of the National Research Ethics Service. Permission has been given by the Research and Development Department within the Trust.

If you would like more information or have any questions or concerns about the study please contact Julie Parkin at j.c.parkin@hud.ac.uk or 01484 472942 (voice mail available) or Dr Joyce Marshall on 01484 473529. Version 2 (11th March 2012)
[Julie Parkin](#)

Appendix 6: Ethics Committee Approval



16 March 2012

Ms Julie Parkin
Professional Doctorate Student
School of Human and Health Sciences
University of Huddersfield

Dear Julie

School Research Ethics Panel (SREP) Submission
Title of Study: "Clinical Leadership on the Labour Ward"

I confirm that your project as titled above has received ethical approval from the School of Human and Health Sciences Research Ethics Panel, University of Huddersfield.

I also confirm that indemnity for this project will be covered by the insurance policy held by the University of Huddersfield, as it falls within the normal range of research activity.

With best wishes for the success of your research.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Nigel King'.

Prof Nigel King
Chair, SREP
School of Human and Health Sciences

Direct Tel: +44 (0)1484 472812
Email: n.king@hud.ac.uk



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Vice-Chancellor: Professor Bob Cryan BSc MBA PhD DSc

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Appendix 7: Observation Schedule

Springdale

Month	Day	Time	Observation (approx. hours)	Interviews
February	Thursday	06.50 19.00	4	
March	Friday	06.45	2	
	Saturday	12.30	2	
	Tuesday	18.45	2	
April	Thursday 5.4.13	10.00	1	1
June	Tuesday	09.00	2	2
July	Monday	15.00	1	1
	Wednesday	10.00	2	2
	Saturday	07.00	2	1
August	Thursday	18.15	2	1
	Friday	16.00	2	
	Sunday	13.00	1	1
September	Friday	13.00	1	1
	Monday	09.00	1	1
	Tuesday	12.30	2	3
	Friday	14.00 19.00	2	1
	Thursday	15.00	2	
	Sunday	08.00	2	3
	Monday	11.00	1	2
October	Friday	17.00	2	1
	Thursday	11.00		1
			Approx. 37 hours	

Northvalley

Month	Day	Time	Observation (approx. hours)	Interviews
April	Tuesday	09.00	2	
	Friday	07.45	2	
June	Tuesday	08.00 19.30	4	
	Thursday	07.45	2	
July	Tuesday	07.45	1	1
	Thursday	10.30	1	2
	Wednesday	15.00	2	3
	Tuesday	21.40	2	1
	Saturday	16.00	2	2
	Sunday	14.00	1	2
August	Friday	16.00	1	1
	Wednesday	14.00		1
	Thursday	10.00	1	2
	Tuesday	13.00		1
	Wednesday	08.00		1
September	Sunday	17.30	2	2
	Monday	11.00	2	3
	Tuesday	17.00	2	2
	Wednesday	19.00	1	2
	Saturday	07.00		
	Sunday	13.00	2	1
	Thursday	17.30	2	1
			Approx. 32 hours	

Appendix 8: Research Participant Information Sheet

Clinical Leadership on the Labour Ward

Midwives who practice on the labour ward on two different sites are being invited to participate in a study to explore their perceptions of clinical leadership. The research aims to examine the characteristics of midwifery clinical leaders on the labour ward and find out whether philosophies of care or service provision have an impact upon these.

Who is organising the study?

My name is Julie Parkin and I am a midwifery lecturer working and studying for a PhD at the University of Huddersfield. I am supervised by Dr Joyce Marshall (University of Huddersfield), Professor Ruth Deery (University of West Scotland) and Dr Pamela Fisher (University of Liverpool).

Why is the research being done?

Leadership is seen as being very important in the NHS today as it is related to helping services to change and develop. Clinical leaders are those clinicians who deliver care on the front line of services and have a direct affect upon them. Increased understanding of the nature of clinical leadership on the labour ward has the potential to assist in the future development of effective clinical leaders that will be of benefit to both women and clinicians working in this area.

Why your views are important

It is important that the study takes into account the realities of practice from the perspective of practitioners working on the labour wards as this should lead to recommendations from the research that are feasible and achievable.

What will be involved if I take part in this study?

If you decide to take part in the study you will be observed alongside your colleagues in the clinical labour ward setting. Observations will be made over a 2 month period and will last for approximately 2 hours each time. No video/DVD recordings will be made. You will also be asked to take part in an interview that should last approximately 1 hour at a place of your convenience. If you have no objections I would like to audio record the interview as this will enable me to concentrate more carefully on what you are saying, rather than on taking notes. If you are identified as a clinical leader during the interviews above I will invite you back for a further interview of approximately 1 hour to explore your experience of this. If you would like to ask any questions about the study, or require any further information I would be glad to speak to you. My telephone number is 01484 472942 (voicemail available) and e mail j.c.parkin@hud.ac.uk . My address is at the bottom of this letter.

What happens next?

If you are willing to take part I will contact you after the initial observations of the labour wards to arrange a convenient time for an interview. You are under no obligation to take part in the study and would be able to leave the study at any time without any negative consequences.

Will the information I give be kept confidential?

All information which is collected about you during the study will be kept strictly confidential. I will not keep your name with anything that has been observed or said, nor will I feed back any comments to anyone. No one who has taken part in the research will be identified in the reports or publications. Ethical approval has been granted from the University of Huddersfield, School of Human and Health Sciences Research Ethics

Committee in line with the recommendations of the National Research Ethics Service. Permission has been given by the Research and Development Department within the Trust.

Thank you for taking the time to read this information sheet and I hope you will be able to come and share your experiences.

Contact for further information

Julie Parkin, Senior Midwifery Lecturer, Huddersfield University, Queensgate Campus, Huddersfield, West Yorkshire, HD1 3DH

Tel.no. 01484 472942 E mail: j.c.parkin@hud.ac.uk

If you have any concerns about the research please contact Dr Joyce Marshall on 01484 473529.

Appendix 9: Consent Forms for Interview and Observation

“Clinical Leadership on the labour Ward”

Research Consent Form

Participant Identification.....

Please initial box

1. I have been fully informed of the nature and aims of this research and consent to taking part in it.
2. I understand that I am free to withdraw from the interview/observation at any time without giving any reason
3. I give permission to be quoted (by use of pseudonym)
4. I give my permission for my interview to be audio recorded
5. I understand that no other person than the researcher will have access to the audio recordings and that audio recordings will be kept in secure storage at the University of Huddersfield and destroyed following analysis.
6. I understand that my identity will be protected by the use of pseudonym in the research report and that no information that could lead to my being identified will be included in any report or publication resulting from this research.

Participant name Date Signature

Researcher Date Signature

Two copies of this consent form should be completed: One copy to be retained by the participant and one copy to be retained by the researcher

Appendix 10: Research Schedule

Stages of Research at Springdale

	Feb 2013	March	April	May	June	July	August	Sept	Oct 2013
Access									
Observation									
Preliminary Interviews									
Interviews nominated midwives									

Stages of Research at Northvalley

	April 2013	May	June	July	August	Sept 2013
Access						
Observation						
Preliminary Interviews						
Interviews nominated midwives						

Appendix 11: Preliminary Interview Topic Guide for Preliminary Interviews with Midwives

Initial Interviews with Labour Ward Midwives

What is your experience of clinical leadership on the labour ward?

What are your views on clinical leadership on the labour ward?

Do you think there is/are particular characteristic/trait(s) necessary to be a clinical leader?

Do those midwives who have these traits hold particular beliefs about care?

Are there any challenges for midwifery clinical leadership on labour ward?

Do you think the organisation of services has any effect on clinical leadership?

Do you think there are any advantages/disadvantages of having clinical leaders on labour ward?

Can you identify members of your team who you feel have the characteristic(s)/trait(s) of a clinical leader?

Appendix 12: Interview Topic Guide for Nominated Clinical Leaders

Interviews with Clinical Leaders

Do you see yourself as a clinical leader on labour ward?

If you do, why do you think this is?

What characteristics do you think make you a clinical midwifery leader?

Why do you think others feel you are a clinical leader?

How have you developed into this role?

What is/are the belief(s) you hold about midwifery care?

Do you think this is an important factor in your role?

Are there any challenges being a clinical leader on labour ward?

What effect do you think your role has in the clinical environment?

What effect do you think the clinical environment has upon the clinical leader role?

Do you think how maternity services are organised has an effect on midwifery clinical leadership on the labour ward?

Appendix 13: Example of Simple Nodes during Early Coding in NVivo

- Node** attitudes and behaviour
- Node** academic versus clinical knowledge
- Node** acting band 7 role
 - Node carrying on from where we left off
 - Node transition to labour ward coordinator
- Node** Agency
 - Node decision making
 - Node deferring to others
 - Node doing things to please
 - Node ways of getting one's own way with decision-making
- Node** band 7s not allocated to care
 - Node having a wingman
 - Node being a wing man
 - Node support for clinical leader role
- Node** being a junior midwife
- Node** being hands on
 - Node being on the shop floor
- Node** not being interested
- Node** visibility
- Node** being soft
- Node** bureaucracy
- Node** challenges
- Node** change and keeping up to date
 - Node being kept informed
- Node** clinical leader development
- Node** clinical leaders
 - Node midwifery clinical leaders' leadership
 - Node team leader
- Node** other clinical leaders
 - Node band 6s as clinical leaders
 - Node consultants as clinical leaders
- Node** clinical leadership qualities
 - Node people skills
 - Node Able to challenge
 - Node able to point out mistakes and correct
 - Node accountability
 - Node advocate
 - Node approachable
 - Node less approachable
 - Node Assertiveness
 - Node Being stuck in your ways
 - Node Bullying

Appendix 14: Example of Domain Analysis

Cover Term	Semantic Relationship	Included Terms
Defer decision making to others = X	X is a reason for doing y	Easier than thinking for yourself = Y
		Feeling insecure
		Coordinator being available
		Trust in coordinator-accepted in social setting
		For safety- ensure effective decisions made
		Don't appreciate what's going on around you
		Accepted practice – part of role of coordinator to be informed- A junior midwife would go to the band 7 with concerns – a band 6 for advice
		Views of who midwives are working with influences their decision making
		The way midwives are treated results in being unable to make their decisions and deferring to senior midwives
		Asking the coordinator, even if I'm nearly 100% sure results in me feeling better
		Shift leaders take on the responsibility of others.

Spradley's (1980) Domain Analysis Work Sheet

Appendix 15: Codes Following Secondary Analysis

1. Agency and power
2. Emotion work
3. Philosophies
4. Knowledge and learning from one another
5. Clinical Leadership
6. The labour Ward environment
7. Relationships
8. Nominated midwives
9. Safety

Appendix 16: Overarching Themes of ‘Safety’ and ‘Identity’

Safety	Identity
<p>Labour Ward Environment is Chaotic, busy, short staffed (6)</p> <ul style="list-style-type: none"> • Unsafe? • Impact on clinical leader characteristics 	<p>Nominated Midwives- as clinical leaders on labour ward (8)</p> <ul style="list-style-type: none"> • Wear ‘game face’ • Oversee others and coordinate care
<p>Clinical leaders oversee and control care to manage the environment. (5)</p> <ul style="list-style-type: none"> • Seen as vital by other midwives • Power and hierarchy 	<p>Agency of midwives affected by environment (1).</p> <ul style="list-style-type: none"> • Given up to nominated midwives due to shared responsibility. • Resistance exists to control and overseeing
<p>Relationships serve to keep labour ward safe(7)</p> <ul style="list-style-type: none"> • Social capital developed 	<p>Socialisation of identity- knowledge and learning from one another (4)</p> <ul style="list-style-type: none"> • Not trained to be leaders but have role models. • Impact on change and development
<p>Love and emotional labour facilitate midwives to practice in a difficult environment (2)</p> <ul style="list-style-type: none"> • reciprocity/productivity/contractual power 	<p>Love and emotional labour facilitate midwives to practice in a difficult environment (2) leads to ownership and identity</p>
	<p>Professional Identity and Philosophy</p> <ul style="list-style-type: none"> • Keeping the doctors out • Gate-keep women and territory • Dissonance • Vulnerability

