Exploring Working Relationships between Midwifery Support Workers and Midwives in a Community Setting

Deborah Ellis

A Thesis Submitted to the University of Huddersfield in Partial Fulfilment for the Degree of Master of Philosophy

November 2013

Copyright Statement

i. The author of this thesis (including any appendices and/or schedules to this thesis) owns any copyright in it (the "Copyright") and she has given The University of Huddersfield the right to use such Copyright for any administrative, promotional, educational and/or teaching purposes.

ii. Copies of this thesis, either in full or in extracts, may be made only in accordance with the regulations of the University Library. Details of these regulations may be obtained from the Librarian. This page must form part of any such copies made.

iii. The ownership of any patents, designs, trademarks and any and all other intellectual property rights except for the Copyright (the "Intellectual Property Rights") and any reproductions of copyright works, for example graphs and tables ("Reproductions"), which may be described in this thesis, may not be owned by the author and may be owned by third parties. Such Intellectual Property Rights and Reproductions cannot and must not be made available for use without the prior written permission of the owner(s) of the relevant Intellectual Property Rights and/or Reproductions.

ABSTRACT

This qualitative study explores the working roles and relationships that exist between midwifery support workers (MSWs) and midwives in a community setting. This research is distinctive from previous studies, as it offers alternative perspectives examining how the role and identity of midwifery support workers were perceived by practitioners involved directly in integrating this new role into an established midwifery service.

In recent years the employment of midwifery support workers in the community has become commonplace, seemingly in response to the reducing numbers of practicing midwives, the economic climate and the need to reduce employment costs within the National Health Service (NHS), balanced against the increasing demands placed on NHS maternity service provision by the UK's policymakers and the increasing expectations of child-bearing women.

A flexible qualitative design was required to explore midwifery support workers and midwives' experiences and opinions of their prevailing relationships. The study assumes a feminist perspective that is used to frame the accounts of the midwifery support workers and midwives. One midwifery support worker and one midwife participated in the pilot study that informed the main study. The remaining four midwifery support workers and a further six midwives agreed to participate in the main study. Semi-structured interviews were used to gather the data. The recorded words of the midwifery support workers and midwives were transcribed and analysed using Mauthner and Doucet's 'Listening Guide', based on their original voice-centred relational methodology.

The data revealed the complex issues of integrating a new role into an established service and the impact on the lives of the midwifery support workers and midwives involved directly in these changes. Issues of power, professionalism and patriarchy featured as a new occupational group aligned itself alongside an established professional group and began to carve out its own areas of practice and define its boundaries. Interviews supported by a feminist perspective enabled the midwifery support workers and midwives to describe and provide details about their experiences of their roles and relationships, thus aligning with the study's qualitative approach.

Acknowledgements

Abbreviations

BBA	Born Before Arrival of midwife or medic
CMB	Central Midwives Board
DH	Department of Health
DoH	Department of Health
EN	Enrolled Nurse
GMC	General Midwifery Council
HoM	Head of Midwifery
HCA	Healthcare Assistant
HCSW	Healthcare Support Worker
LREC	Local Research and Ethics Committee
MSW	Midwifery Support Worker of Maternity Support Worker
NA	Nursing Auxiliary
NHS	National Health Service
NMC	Nursing and Midwifery Council
NVQ	National Vocational Qualification
R&D	Research and Development
RCM	Royal College of Midwives
RCN	Royal College of Nurses
RM	Registered Midwife
RN	Registered Nurse
SEN	State Enrolled Nurse
SRM	State Registered Midwife
SRN	State Registered Nurse
UK	United Kingdom
UKCC	United Kingdom Central Council

Table of Figures

Table of Contents

Word Count: 51147

CHAPTER ONE

<u>**Introduction and Overview of the Study**</u>

This study explores the role of the Midwifery Support Worker (MSW) and the perceptions of the MSWs and midwives involved in implementing this new role into an established midwifery practice, in a community's maternity service. Furthermore, this qualitative study examines the working relationships constructed between these two health practitioners whilst adjusting to this new working practice. The MSWs and midwives were employed in a hospital's National Health Service (NHS) Foundation Trust organisation in a northern English town. I intend to outline the key drivers that governed the UK midwifery policies that affected the employing organisation, and I will also consider how they influenced maternity service provision. To date, I have found that research concerning MSWs has focused on how to maintain the current provision of maternity and accommodate improvements in service, in an economic climate where organisations are compelled to remain within budgetary constraints. In this study I will discuss how the role of the MSW emerged in response to meeting the inherently increasing demands placed upon maternity services. The focus of the study remains on the practitioners providing frontline maternity services, fundamentally exploring how the MSWs and midwives related to each other and where they placed themselves within their partnerships. In addition, I will examine how these practitioners defined their roles whilst working together and how they identified and maintained their boundaries.

This chapter presents an introduction to my research and how the study was conceived in relation to my own professional working practices as a community midwife. The scene is set to enable the reader to understand the context in which the study took place. I explain the need for my study and outline its aims, and I briefly discuss the feminist perspectives that frame and thread this study and follow them up in Chapter Three with an in-depth review of feminist theory. Finally, I conclude this chapter with an overview of the structure of the thesis.

Background of the researcher

Initially I trained as a nurse before I became a midwife. As this study commenced I had been qualified as a midwife for ten years, and had worked as a community midwife for the latter three years. During my time as a hospital midwife I experienced working alongside other practitioners, including Healthcare Assistants (HCAs). Notably, some of these practitioners were to become the MSWs of the future and included the Trust's future "pilot" MSW. It was by sheer coincidence that the "pilot MSW" and I should both embark on our community experiences on exactly the same day and happen to work within the same team as each other. Once in the community, our paths crossed occasionally, which allowed me to take a

glimpse of the MSW role in action. However, I moved to another area of the town to work with a different team of midwives whilst the pilot MSW remained with the same team of midwives. A short time after I joined this team, an MSW was also allocated to the team, but this experience was short-lived, as she was moved to another team which was deemed to be struggling with workload issues. I recall feeling frustrated having had only a limited opportunity to work alongside an MSW. However, I am able to reflect on the benefits of this missed opportunity in three ways: firstly, it helped me to observe the emerging MSW role and its development, secondly, it enabled me to monitor the role's impact on community midwifery services and thirdly, it provided an area of research at a time when I was searching for a project and one that would fulfil the requirements of a postgraduate study. Effectively, my experience was the basis for launching this study. It is only on reflection that I recognised the significance of the events leading up to the decision to undertake this research.

The need for this study

I have outlined already that the impetus for this study and the resulting thesis was my role as a witness to the emergence of the new MSW role in the community, and I recognised that I also had an appreciation of the knowledge and skills of some of the MSWs, having worked alongside them in their HCA roles in the hospital. Indeed, a prerequisite of the MSW role included a substantive background in maternity care; therefore, recruits were drawn from existing hospital-based HCAs. This staff group was knowledgeable and experienced around childbirth matters and child-rearing in a hospital maternity setting, having worked in the hospital for a number of years. Interestingly, this draws a parallel with Thornley's (2000) findings, in that the average length of service for NHS HCAs is around 12 years – a phenomenon of significance later in the study.

Although I was fairly new to community working, I perceived a feeling of unrest as the midwives adjusted their working practices to accommodate this additional staff member into their teams and daily working practices. Change is an integral part of the NHS, and the service is recognised as being in a continuous state of organisational restructuring (Kessler et al., 2007), frequently required to implement the new recommendations of its governing bodies and aiming at working smarter and becoming more efficient (Parish, 2008). In effect, the Trust acquiesced to employing new strategies to improve its maternity service. As a result, MSWs were recruited to work in the community. On reflection, this was an insightful move on behalf of the Head of Midwifery, as the MSWs were employed some time before the publication of the recommendations of the Changing Workforce Programme NHS Modernisation Agency (NHS Employers, 2006) to include MSWs in maternity services.

Since the rapid rollout programme, the number of MSWs employed in the UK has increased exponentially, something that was noticed in this study, too. As a result of recruiting hospital

HCAs to community MSW posts, hospital HCA vacancies were created. As recently as the beginning of the 21st century it was reported that there were no current reliable data or official records of the numbers of ancillary staff and HCAs employed in the NHS (Thornley, 2000). Estimations suggest that there are around 280,000 support workers employed within the NHS in England, accounting for 43% of healthcare nursing staff (RCM, 2010). Although it has been acknowledged that this cohort makes a significant and valuable contribution to the care of mothers and babies (DH, 2004; NLIAH, 2010), clearly in research terms this staff group has been somewhat neglected, reflected in the lack of available evidence, and there is a distinctive absence of evidence documenting the perspectives of the workers themselves.

In regard to the current research, there were even fewer studies addressing the qualitative nature of the MSW role and the construction of relationships between MSWs and midwives. However, since the beginning of this investigation, and in the wake of the employment of MSWs throughout the UK, there has amassed an ever-increasing amount of documentary evidence on the subject, although it has continued to overlook the personal perspectives of working relationships in light of this emergent assistant role. This was another of the reasons why I chose to investigate the role from a working relationship perspective and to document the personal views of the staff involved in this new working practice.

As previously discussed, I had already begun to observe how the MSWs were integrating into the community and had noted how some teams were adjusting to the new role more quickly than others. As a community midwife I gained an insight into how some individual midwives coped with this new working arrangement. Furthermore, I witnessed discussions between midwives who debated the pros and cons of employing community MSWs, usually at collective gatherings such as meetings or training sessions. Occasionally, I had the opportunity to work alongside some of the MSWs in the community, should they call me about a woman who had a breastfeeding problem (in my previous role in the hospital I had been a breastfeeding co-ordinator, before taking up my community midwife post). I began to listen to their experiences and how they themselves related to the midwives and adjusted to community working. It became apparent there were very real controversies between the MSWs and the midwives, in relation to their roles and their relationships. As I have already mentioned, I had an appreciation of the knowledge and skills they had acquired as hospital HCAs and I could not understand why they were experiencing problems now. As I started to listen to the stories of the MSWs I was curious and wanted to know more. I had some understanding that they were struggling to assert themselves in their new role and had had difficulties in assuring the midwives they were indeed competent in their skills. However, I was not to know that I had only seen the tip of the iceberg. These early observations posed more questions than I could answer, and I felt obliged to search out some answers, and so it was necessary that I embark on this study.

Aims of the study

The aims of this study are:

- To explore critically the working relationships between MSWs and midwives, as well as their perception of the MSW role and its boundaries, within a community setting.
- To review critically the development of the MSW role.
- To inform local policy and practice in relation to the integration of community MSWs into maternity services.

Setting the scene

This study takes place in a NHS community setting in a northern English town. The scope of this work is limited to the experiences of five MSWs and seven midwives in the local NHS maternity service.

In maternity services throughout the UK, in light of the modernisation process of the NHS (DH, 2000; DH, 2004; DH 2007), the Changing Workforce Programme NHS Modernisation Agency (NHS Employers, 2006) commissioned a restructuring of services, including maternity provision. The restructuring included initiating a rapid rollout programme employing maternity support workers in maternity services co-ordinated by an NHS Employers Large Scale Workforce Change (LSWC) Team. The programme aimed to promote service improvement and development and provide benefits to clients and healthcare staff. This national programme was initiated in response to Maternity Standard (no. 11) of the National Service Framework (NSF) for Children, Young People and Maternity Services (DH, 2004) whose primary focus was to improve access and raise standards of care. The LSWC team recognised that MSWs had an important role in providing support to midwives and in the provision of maternity care to women and their babies. The project was also linked closely with the Department of Health's action plan for Midwifery Retention and Recruitment (DH, 2004), at a time when the UK's birth rate was rising whilst the midwifery profession was experiencing recruitment and retention difficulties (Curtis et al., 2006).

The NHS Trust's maternity unit where I was employed did not form part of the participatory group, but as I have mentioned, it did replicate this new working practice and began to employ MSWs in the community, just before the national programme commenced. It may be construed that the employment of maternity assistants was not an entirely new working practice, as the maternity service in this study already employed HCAs on maternity wards. The HCAs were trained to National Vocational Qualification (NVQ) stage 2, and this new post provided promotional opportunities enabling successful candidates to progress to NVQ level 3 along with an increase in salary.

The midwifery team allocated the pilot MSW, became the "training team" for newly appointed MSWs. Each MSW underwent a six-month period of apprenticeship working alongside this same team of midwives, and the pilot MSW who effectively "showed them the ropes." Initially, the MSWs were closely supervised. On completion of the apprenticeship period, there followed a period of consolidation and the MSWs became more distantly supervised. As each MSW completed their apprenticeship, so another MSW would be appointed in the community. Thereafter, the "trained" MSWs moved to work in neighbouring teams, thus enabling the next MSW to take their place in the training team. This pattern of working continued until four of the five teams had an MSW in their team.

An insight into feminist perspectives

Liz Stephens (1999) posed the question 'Why aren't midwives feminists?' In answer to her query, I believe some midwives do not have an understanding of what is meant by the term "feminism," which is where I found myself at the beginning of this study. As my knowledge expanded, though, I realised that for others their denial may be used as a self-protection mechanism to defend against exposing themselves to negative opinions, whilst others may choose not to disclose their feminist views overtly, or more simply do not want to be labelled in that way. For the greater part of my working life I have been a midwife, a woman employed within a predominantly female workforce, working with women and their families and striving to improve the lives of other women and their families. This echoes the approach of Judith Stacey (1991), who views feminist research as 'research on women, by women, for women' – a notion with which I identify, as I recognise it forms part of the aims of this study. I have evolved to recognise my own feminist values, and I therefore identify myself as a feminist.

Distinctions can be made between the many forms of feminism that exist, although it may be argued that all feminists are unified by their commitment to the emancipation of women (Hoffman, 2001). Feminist perspectives have evolved over time and moved away from traditional masculine subjective-objective ideologies (Plummer & Young, 2009), and they are now beginning to articulate the findings of the female world (Belenky et al., 1986), endeavouring to make women's voices heard (Gilligan, 1982; Oakley, 1993).

This study aimed at investigating relationships, and one of its primary concerns was to gain insights into the lived experiences of the participating MSWs and midwives. Taking a feminist approach seemed most appropriate, as it best articulated the meaning of the practitioners' voices by allowing them to be heard. This study takes a qualitative approach that seemingly fits with feminist inquiry (Plummer & Young, 2009), as it is an interactive process and relies on authenticity, reciprocity and intersubjectivity between me and the practitioners. Additionally,

taking a feminist approach enabled reflexivity to be weaved into the research process and in Chapter Three I offer a more in-depth review of feminist theory.

The structure of the thesis

This thesis contains six chapters. I next outline the structure of the thesis and include a summary of each chapter.

Chapter 1 Introduction and Overview of the Study

In this chapter I explore and discuss my motives for undertaking this study with the MSWs and midwives and rationalise why I have chosen to focus on their working relationships. The chapter sets the scene by offering an overview of the restructuring processes of the NHS in its attempt to keep pace with the demands on maternity services. The aims of the study are outlined and a summary of the theoretical concepts underpinning the research is provided. The chapter concludes with an overview of the structure of the thesis.

Chapter 2 Literature Review

Here I sketch out the historical and cultural, social and political aspects of the professionalisation of midwives. I explore further how the role of the MSW has evolved, examine its integration into maternity services and discuss the formation of roles and boundaries. In the final part of this chapter I examine the development of professions, before reviewing the patriarchal influences and power relations that are proposed to exist within professions.

Chapter 3 Theoretical Perspectives, Methodology and Methods

In this chapter I provide an account of the theoretical perspectives used to inform the study. An in-depth review of feminist theory is provided, added to which I consider my own standpoint. I also explore how taking a qualitative approach supports the study, and I outline the methods used to collect and discuss the data and how the voice-centred relational method (VCRM) assisted in analysing the data. I consider the ethical issues that arose as a result of the study, which includes me as the researcher, in terms of my insider/outsider status, and also establish how I have used reflexivity throughout this study. The chapter concludes with a discussion of the study's rigour.

Chapter 4 Findings of the Study

The emerging themes are identified by analysing the data. These are subsequently ordered into the overarching theme of the study with organisational themes supporting the main one. The data is further organised through the identification of basic themes underpinning the organisational themes. A diagrammatic illustration of the themes is provided (See Figure 1).

Excerpts from the data are included, to support and make a case for the emergent themes and at the same time help the reader to envisage live dialogue.

Chapter 5 Discussion of the Findings

In this chapter I present the key findings of the accounts of the MSWs and midwives and consider them in relation to the concepts discussed in Chapter Two. I also discuss relevant research that supports the findings. I draw together these aspects and condense them in the conclusion of this chapter.

Chapter 6 Summary, Conclusions and Recommendations

This chapter concludes the study and acts as a platform on which to reflect on the significance of the findings. I provide examples of historical parallels that relate to the findings of the study, and I also discuss the strengths and limitations of the study and contemplate the implications for practice, policy, education and future research, before providing recommendations for the future. The chapter concludes with a summary of my personal research journey.

CHAPTER TWO

Literature Review

In this chapter I offer an overview of the significant historical, social and political issues that have influenced midwifery in the UK. I also provide a review of sociological theories and address the notions of professionalisation, development of professions and how professionals have come to acquire their status. Furthermore, I consider these aspects in relation to midwives and midwifery. As this is a study of the working relationships between MSWs and midwives, I outline the concepts of power, professional closure and patriarchy, as these are considered some of the key theories to affect the construct of relationships.

In the beginning: midwives in ancient history

It appears that documenting the general work of midwives was not a priority of past historians, and the formal education of midwives has waxed and waned throughout the ages, so very few texts exist that were written by midwives that recorded their day-to-day activities. Consequently, it has been necessary to gather evidence from other sources in order to weave together a history of midwives' working lives. One of the earliest and most well-known references appears in the Old Testament, where Shiprah and Puah (Hebrew midwives) are ordered by the reigning Pharaoh to kill all male babies (Exodus, Chapter 1, Verse 20). Midwifery has been practiced for centuries, with women being attended by an experienced woman from her community, someone who has herself given birth and acquired skills under the tuition of even older, more experienced women. Thus, midwives took on assistants who would follow in their mentors' footsteps until they themselves became accomplished practitioners. Valerie French (1986) wrote of midwives practicing in western Roman regions being born into servility, evidenced as their funerary epitaphs recorded their freed status, and which testified to the fact that they had earned enough money and standing in the communities they had served to acquire their freedom. French (1986) hypothesised that as midwives had the ability to practice into old age, it followed that apprentice midwives, possibly their daughters or slaves, were taught the necessary skills from a young age. This reasoning is supported by other funerary epitaphs that note the age on death of midwives, with some stating that they were daughters of freed midwives, their young age on death suggested they were likely to have been apprentices.

Midwives throughout the middle ages

Christianity was introduced to Britain in the second and third centuries during Roman occupation followed by Anglo Saxon invasion; its invaders became converts and the Church

became the focus of society. Throughout the high Middle Ages (1000-1300 AD) the Church became a powerful and highly organised institution and continued to exert its influence on society. Monasteries erected throughout England saw monks ministering to the sick and elderly members of their own religious orders (Towler & Brammall 1986). Subsequently, monastic infirmaries were established where the lay community were nursed by monks and nuns. Women were considered inferior to men, with the exception of nuns and nurses, who became well-respected (Burkhardt & Nathaniel, 2002), and nursing the sick became seen as a charitable act by the Church, whereas curing the infirm brought condemnation.

No midwifery references are to be found between the fifth and eleventh centuries in England, an unsurprising fact, as the country experienced invasion and pillage and life expectancy was short. Towler & Brammall (1986) surmised that midwives continued to practice their skills and speculated that all practitioners were uneducated. However, they also noted that 'some would have empirical knowledge, skills and abilities, whereas others would be both ignorant and unskilled' (1986 p.22) and conjectured that almost certainly all practitioners were female. It is noteworthy that they made no mention of how midwifery skills were acquired or retained.

In the thirteenth century, barber-surgeon guilds were established in an attempt to order entry into the trade and to standardise practice (Rowland, 1981). These practitioners were not doctors but tradesmen skilled in the use of instruments that midwives were prohibited from using. Midwives were compelled to call upon the barber-surgeons' skills in cases of obstructed labour, and these practitioners were 'neither challenged by the Church nor prosecuted by the State' (Towler & Brammall, 1986, p. 29). It is also noted that during the thirteenth century, institutions were founded where medicine and law could be studied, most notably Oxford and Cambridge universities, where learning was undertaken exclusively by men, thus barring women and midwives from academia. Nonetheless, midwives remained the empiricists of childbirth, accumulating knowledge and skills through experience and passing on their skills to their apprentices, and historians generally agree that women's health remained women's business throughout the Middle Ages (Rowland, 1981; Grielsammer, 1991). Since the beginning of the thirteenth century, writings on women's health and healthcare began to flourish, and Green (2009) recorded that before the start of the eighteenth century, 250 works were published in Europe, although only five texts were written by female midwives. Green (2009) also stated that there was competition over medicine in the high Middle Ages, but not between men and women per se, but between empirical knowledge and book-learnt knowledge, where women were excluded from book learning notwithstanding their background, class or status. Furthermore, Green (2009) observed that men had never totally been excluded from childbirth, as they were tasked with peripheral roles such as calling for the midwife, and physically supporting labouring woman, whilst male physicians attended complicated births and sutured wounds sustained through birth.

Notably, Greilsammer (1991) outlined (from a Flemish source) the case of a midwife called Catherine Andricx, in the town of Ghent, who recruited and trained apprentice midwives. She made a complaint to the town's alderman claiming that one of her pupils, Jehanne, was stealing clients from her before her training period of two years was over, following which the midwife would be entitled to a percentage of her earnings until her counsel was no longer needed. This type of apprentice agreement appears representative of the period throughout Europe and is relevant to this study, as it is an early source illustrating a model of apprenticeship and pertains to the training and education of MSWs.

A fundamental change occurred in the sixteenth century whereby midwives became auxiliaries of the Church, which, as a patriarchal institution, distrusted all women, including midwives (Bullough, 1974) based on theological beliefs originating from Eve's transgression. In 1512, the Church passed an Act whereby midwives were required to swear an oath to the Church in an attempt to regulate their practices and curtail them from condoning or carrying out contraception or abortion. They became responsible for carrying out emergency baptisms of newborns in the absence of a priest, and in the case of a mother dying in childbirth they were expected to cut out the child and carry out baptism. The aim was to preserve patriarchal Christian order, but it was also considered a way of subduing and controlling women and circumventing the practices of midwives.

Midwives in the renaissance and reformation

The sixteenth century encountered two great movements, namely the Renaissance and the Reformation. According to Burkhardt & Nathaniel (2002), the former heralded an era of the quest for scientific and intellectual knowledge, and medicine began to escape its theological origins. Cartesian philosophy began to replace religious beliefs, based on the work of Rene Descartes (1596-1650), who theorised that all things physical could be analysed and understood. The second movement, the Reformation, brought about a division in the Church, as Catholicism struggled against the Protestant faith spreading across Europe, and as a result the power of the Catholic Church began to decline. Monasteries and their infirmaries closed and religious orders were expelled from hospitals, becoming places of horror (Donahue, 1996), with nursing duties assigned to women of unqualified and undesirable origin. The "sworn oath" of the midwife became obsolete as male attendance began to increase. Medical men attended more complicated births and later more routine ones as they claimed to have greater scientific and technical knowledge than the female midwives, and so the rise of the male midwife began, very likely assisted by the invention of obstetric forceps. However, there was resistance, as the general public believed men practicing midwifery was licentious. Medical men considered midwifery to be women's work and demeaning, and therefore it should have no place in medicine. Midwives judged their own livelihood threatened. Henceforward, a challenge between the genders ensued over the dominance of

midwifery practice, and medical men attempted to differentiate themselves from midwives (Towler & Brammall, 1986). Distinctions between the practice of normal and abnormal midwifery began to establish, and the division of labour started to split between 'assistance at childbirth' (female-orientated) and 'intervention in childbirth' (male-orientated) (Abbott & Meerabeau, 1998). Medical men were seen to take the highly paid jobs whilst the midwives were left the poorer ones. Furthermore, highly educated women had been seen to act as midwives, but numbers decreased with the decline in pays and status, and lesser well-educated women were attracted into the occupation; Dickens' portrayal of the gin-swigging midwife "Sairey Gamp" became a synonymised character of the profession. However, the midwives or local women who attended to women of the poorer classes were in fact empiricists taking their knowledge from learned experience. The English philosopher Thomas Hobbes (1588-1679) was recorded to have said 'that he had rather have the advice, or take physique from an experienced old woman, that had been at many sick people's bed-sides, than from the learnedst but unexperienced physician' (Hobbes, cited by Aubrey, 1898, cited by Clark, 2007). Throughout the next two centuries, midwifery continued to be practiced in its common place, the community, all the while pursued by medical men who persisted in their campaign to oust midwives from their roles, as they sought to 'protect their sphere of practice and their income' (Kent, 2000, p. 49).

Control of midwives in the 20th century

In a bid to protect the occupation of the midwife, social reformers assisted in setting up the 'Matron's Aid' or 'Trained Midwives Registration Society' (becoming the 'Midwives Institute' and later the 'Central Midwives Board') with the aim of re-establishing the role of the midwife, by initiating a recognised training scheme and registration system. A Private Members Bill was introduced into the Commons in 1890, eventually gaining approval in 1902, and in spite of vehement opposition from the medical profession the first Midwives Act was passed. However, the Central Midwives Board was placed under the control of the General Medical Council, and medical men once again assumed power over midwives and midwifery. The outcome was viewed as a double-edged sword, as arguably the process legitimised midwives by identifying midwifery as a profession, but it also ensured midwives remained subjugated by the male medical profession. Indeed, Hearn (1982) argued the route of professionalisation is a process whereby the male assumed control of female tasks. In this instance, male doctors acquired control not only of the division of labour but also over female workers (midwives), who were seen to take on a subordinate role. Nevertheless, as a result of the Midwives Act, midwives could enrol on the register, and women who had practiced for a year and who could produce a reference of good character were eligible to register as "bona fides." Otherwise, all other women practicing midwifery had to pass an examination to prove their competence, something which proved to be cost-prohibitive to the majority of working-class women who were providing midwifery services at around this time (Leap & Hunter, 1993). The actions of

the profession during this period were an example of an inclusionary strategy, a professional closure strategy considered later in this chapter.

The Midwives Act of 1902 aimed to standardise the training and education of midwives and control their practice. It was seen as pivotal, as it lent itself to the professional status of the midwife (Cowell & Wainwright, 1981), thus making it illegal for any unqualified midwives to practice midwifery. Unregistered midwives who had had no formal training lost the right to be called midwives (Leap & Hunter, 1993), and instead they became known in the communities where they worked as "the odd-job woman" or "the woman who does." These "handywomen," however, continued to practice their learned "midwifery" skills, as they were often the ones called upon by the poorer families to attend births because their services were more affordable than those of the trained midwife or doctor. Leap & Hunter (1993) also recorded that handywomen worked alongside trained midwives attending to the needs of women during childbirth, the handywomen often being left in charge of caring for the women in the days following the birth. This scenario equates to the system that presently exists in the Dutch health service and one that is currently emerging in the UK (Wiegers, 2009). Further recognition for trained midwives emerged in the form of the Midwives Act of 1936, when they were awarded salaries and pensions from the state as well as a strategy that was seen to strengthen their professional status and standing in relation to other professions, but one that also assured the redundancy of the handywoman.

In outlining the history of midwifery, I have highlighted areas where apprenticeships and the acquirement of skills saw the midwife as an empiricist. The trained professional only materialised in the twentieth century after centuries of being "untrained" and "unregistered." In comparison, nursing and midwifery assistants have only recently become "trained," although they remain unregistered and they have been recognised in their "untrained" capacity for centuries. Furthermore, throughout this historical overview, reference is made to the medical profession, the Church and the state, as medicine evolved from theological theory supported by the state. Of more significance are the relationships between medical men and midwives and the apparent patriarchal tendencies, and subjugation of women by men, through the Church, through medicine and through education and the acquirement of skills. Patriarchy as a social theory is discussed later in this chapter.

The emergence of the midwifery support worker

The role of the Midwifery Support Worker (MSW) owes its existence to the role of the Healthcare Assistant (HCA). Assistants appear to have been ensconced in the field of nursing throughout history, and mention is made of nursing assistants in the Crimean war, with Florence Nightingale noting the merits of the 'nursing aides' and their contribution to the nursing team (Stokes & Warden, 2004). This unqualified nursing support role has become

embedded within the nursing workforce but has remarkably remained unregistered throughout time. In context, nursing became a registered profession in 1919, whilst around the same time a gap in legislation allowed "non-registered nurses" to continue in their role.

During the Second World War, in response to the shortage and cost of employing registered nurses, a secondary level of nursing was founded, and the "assistant nurse" role was introduced, requiring a shorter period of training than that of the registered nurse, and placed on the roll of the General Nursing Council. The removal of "assistant" in its title was prompted by the Nurses' (Amendment) Act (1961), as it was considered to allude to a subordinate role in relation to the registered nurse and its lowly status rendered it unappealing as an occupation, whereas the newer title of "enrolled nurse" proposed to reverse negativity surrounding the role in a bid to recruit enrolled nurses (Kessler et al., 2012).

In the meantime, the ancillary role of the nurse support worker, better known as the "nursing auxiliary," had embedded itself within the nursing workforce, and the Briggs Report (1972) acknowledged the role and proposed reinstating its former title of "nursing aide," though it is not clear why this title change should be invoked, although Kessler et al. (2012) surmise that reasons may have been around the function or purpose of the job.

The nursing auxiliary role was seen as low-level nursing revolving around tasks of a 'dirty' nature (Johnson, 1978). Certainly, as a trainee nurse in the mid-eighties, I was often apprenticed alongside an experienced nursing auxiliary to be introduced to bed-making and bed-bathing, toileting and feeding patients. I remember feeling the need to keep pace with these hugely experienced women (throughout my entire nursing career spanning 10 years, I never encountered a male nursing auxiliary) and attempted to become as adept in these skills as they were, in order to prove my worthiness in my bid to become a qualified nurse. Education of auxiliaries was not seen as a priority, as highlighted in a survey carried out for the Briggs Report, which found that less than half of the respondents had received an induction to the role, and less than a quarter had received any further training.

However, during the latter part of the 1980s, the role was reassessed and re-evaluated and became pivotal in light of the United Kingdom's Central Council (UKCC) for Nursing, Midwifery and Health Visiting's 'Project 2000' report (UKCC,1986), which recommended substantive changes to nurse training. One of the key proposals was to move away from the apprentice-type, on-the-job training that nurses had previously undertaken, to a more classroom-based learning that included much more theory and understanding of research. Schools of nursing became affiliated with local universities in an attempt to assist in professionalising the nursing role, and universities eventually took over accountability of student nurse education from District Health Authorities (DHAs) (Abbott & Meerabeau 1998). Up until this time, student nurses had been a source of manpower in delivering patient care,

but these changes required NHS organisations to seek out other sources to replace the gaps left by student nurses. At around this time, the Royal College of Nurses (RCN) had been campaigning for the removal of the State Enrolled Nurse (SEN) role and for nurses to be a one-practitioner role. Many SENs opted to undertake further training to convert to registered nurse status, and as a result there were not enough SENs to bridge this same gap (Kessler et al., 2012) for trainee nurses to be supernumerary.

The government provided limited funds to cover employing a lesser qualified person to replace student nurses, and so the role of Healthcare Assistant (HCA) was introduced. The HCA role required the post holder to undertake a standardised scheme of preparation, as the post was accorded a role of clinical support and was linked to National Vocational Qualification (NVQ) accreditation. In accordance with the NHS Agenda for Change pay scale, NVQ level 2 equated to Band 2 pay on the pay scale. However, the pay scale included Band 3 pay, which required the clinical post holder to be working at a more senior level, i.e. the post holder needed NVQ level 3 accreditation. In consequence, a tiered system of HCAs developed and indeed remains in operation in today's NHS. The NHS Modernisation Agency's Changing Workforce programme proposed further development of the HCA post (NHS Employers, 2006), and it suggested the introduction of an assistant practitioner, elevating the post to Band 4 pay whilst operating at a NVQ level 4 standard, which ironically equates to the level at which SENs previously functioned. Within the hospital where I worked, many Nursing Auxiliaries (NAs) opted to undertake NVQ level 2 training to become HCAs whilst working on the maternity wards, and they acquired the title "Healthcare Assistant." (HCA). Those HCAs who secured posts within the community were expected to function at NVQ level 3 and aim to achieve accreditation at this level to validate earning a level 3 wage. It was also noted that the move into the community prompted a change in title to Midwifery Support Worker (MSW). This is an idiosyncrasy in this study, as throughout the UK most midwifery assistants are known as Maternity Support Workers.

In mapping the progression of the nursing profession, it is evident that the advancement of the HCA through the different levels followed suit. Other influential factors have included the introduction of the European Union Working Time Directive. The restrictions placed on junior doctors' working time had a knock-on effect, and nurses took on some of the technical skills junior doctors would have previously performed. In consequence, HCAs took on some of the duties and care that nurses had undertaken in the past, which in turn effectively enabled HCAs to become skilled in traditional nursing tasks.

Similarly, in midwifery, student midwives had taken on supernumerary status and could not be included in staffing wards and workloads. Again, schools of midwifery found association in universities in order to progress professionalisation and standardise midwifery education throughout the UK. However, midwifery declined to become part of the Project 2000 scheme,

based on the supposition that it was not appropriate to place midwifery in the realm of health and ill health. Midwives considered pregnancy and the birth experiences of women to be normal life events and judged them to be more appropriately based within a sociological perspective (Kessler et al., 2012). Hence, midwifery developed a system of education independent of nursing, in a bid to remain autonomous and define the features of the profession. These actions validated their claim on midwifery services within the marketplace and reflect aspects of Larson's (1977) professional project theory, discussed later in this chapter.

In summary, HCAs and MSWs have remained unregulated and unregistered, although they are seen as an integral part of nursing and midwifery workforces. HCAs and MSWs work alongside and support registered professionals. Moreover, they assist in the care of clients, and for these reasons they have become pivotal in service provision within the NHS. Their lack of regulation within the UK has been an issue of much debate, and even now it remains unresolved. However, the infrastructure of their learning framework (NVQ accreditation) has created opportunities to develop skills and deepen knowledge, reflected in being rewarded with higher earnings.

Professions, professionals and professionalisation

One of the aims of this study was to examine the roles and boundaries of MSWs and midwives and to explore their working relationships. These were two distinctive working groups defined by the Trust's employment contracts and role descriptions. Midwives are awarded professional status by virtue of their registration with the Nursing and Midwifery Council (NMC), whilst MSWs undertaking similar duties make no claim of professional status and remain unregistered with any professional registration body. In the UK, midwifery made a formal claim to its professional status following the Midwives Act of 1902, although the profession has not been without its struggles in maintaining its identity since this time, as highlighted earlier in this chapter. As the researcher I believed it was critical to examine and understand clearly what makes a profession a profession and a professional a professional, and to appreciate the whole process of professionalisation.

Defining professions

Historically, law, medicine and the clergy were perceived as the archetypal models of established professions in society (Abbott & Wallace, 1990; Perks, 1993). These professions were defined by Elliott (1972) as "status professions" as opposed to "occupational professions." Entry into the status professions was considered more difficult for lower social classes, to whom the occupational professions proved more accessible, as the work they undertook was allegedly "supervised" and "applied" (Etzioni, 1969; Abbott & Wallace, 1990)

rather than the more autonomous work the classical professions assumed. Etzioni (1969) goes further and classifies occupations as "professions" and "semi-professions," whilst Macdonald (1995) recognises that Etzioni had overlooked workers that could be neither, and therefore added the term "non-professions" in his work. These semi-professions began to establish themselves around the beginning of the nineteenth century as occupations became specialised and began to claim professional status – as so did midwives. Meanwhile, the status professions continued to provide a model against which the emerging professions could measure their professional status, and this benchmarking system as recognised today enables other occupations to claim professional status.

Functionalism

During the mid-twentieth century, studies of the sociology of the professions were dominated by functionalism, due in part to the work of Emile Durkheim. In the late nineteenth century, Durkheim (1958, cited in Macdonald, 1995) studied the individual and society, and acknowledged that the relatively new science of sociology could examine the processes of social change and the conditions of social order in an attempt to reorganise society. Durkheim became an influential figure, and it is apparent throughout his work that he remained focused on morality. The emphasis he placed on professional ethics, embodied by professional institutions, was seen as a stabilising feature of modern society, not unlike the organisation of midwives and their education after the implementation of the 1902 Midwives Act. However, Robert Merton (1957), a supporter of functionalism, realised that Durkheim's work was not beyond reproach, and like Mills (1951) he studied organisations, bureaucracy and bureaucrats and noted that these were becoming the powers in society that affected and somehow helped define professions.

The "traits" approach

In defining the sociology of the professions, social theorists have attempted to differentiate professions from occupations by identifying particular characteristics. Goode (1957) provided a classification structure in an attempt to define particular "traits" of professions that make them distinct from occupations, whilst Parsons (1954), supporting functionalism, placed emphasis on the trait of altruism, an ideology of public service, in order for certain occupations to be termed "professional."

In summarising the characteristics of professions, Abbott & Wallace (1990) included the monopolisation of particular forms of expertise, the erection of social boundaries around them through entrance qualifications and extended training, an ideology of public service and altruism – all self-policing mechanisms constructed through their own internal criteria of standards maintained by the profession itself. Similarly, Dietrich & Roberts (1997) used a

classification approach that attempted to verify that professions are indeed more than an occupation, having unique characteristics. They identified professionals required intellectual and practical training, providing them with specialised skills. Furthermore, the formation of a professional body accepting the responsibility for maintaining the integrity of the profession offers grounds for professionalisation.

Indeed, midwifery can identify with the "traits approach," although it is only an ideology and does not account fully for the differences that preclude an occupation becoming a profession. The traits approach to the professions was seen as a sociological task (Becker, 1970) cataloguing typical characteristics that could be attributed to professions and was criticised as a system of classification and merely a description and not an analysis. Neither does the traits system provide any explanation of the power distributions between consumer and producer.

Interactionism

Functionalism continued to dominate sociology until the mid-twentieth century, when American sociologists Becker (1961), Hughes (1963) and Friedson (1970) put an alternative spin on things whilst studying the sociology of occupations. They took account of the actions and interactions of individuals and groups whilst at the same time examining social structures and peoples working lives. Their investigative format parallels with the construct of the present study, as it examines the relationships between the MSWs and midwives. Becker et al.'s (1961) *Boys in White*, and Friedson's (1970) *Profession of Medicine*, focused on individuals in society and how they developed their careers, suggesting that altruism was an ideology, as medical men exhibited cynicism and exercised their power in their respective studies.

Power and the professions

Johnson (1972) introduced the radical notion that a profession was not only an occupation but was also the mechanism that controlled an occupation; therefore, midwifery controlled midwives and the medical profession directed medical men. Central to this new critical theory was the concept of "power." The institutionalising power relational concept displaced previous functionalist and traits approach theories, therefore ensuring the control of occupational activities.

Other sociologists recognised that professions were assuming a power approach whereby professions maintained their autonomy with very little outside interference or supervision, and they were able to exert control over their members and shun rebellious members, echoing the organisation of midwifery in the twentieth century in how its professional body policed its participants. Again, eminent American sociologists such as Hughes (1958) wrote of 'licence

and mandate' that enabled professionals to maintain control of their work through their influence on society, whereas Friedson (1970) coined the term 'organised autonomy' and alluded to this dominant force that was exerted over others.

A more radical line of questioning was proposed by Hughes (1963), who realised that wrong questions were being asked in an attempt to define occupations in his studies. As such, he changed the question *'Is this occupation a profession?'* and instead asked:

> *What are the circumstances in which people in an occupation attempt to turn it into a profession and themselves into professional people?*
> *(Hughes, 1963)*

Midwives in the UK found themselves in such as position in the late nineteenth century, prior to the introduction of the 1902 Midwives Act. This radical shift was Hughes intimating action and not structure in sociological research terms, i.e. it was the people in the job that helped define their own profession. However, Becker (1970) and Friedson (1983) offered an alternate view, in that it was lay-people who decided who or what constituted a profession:

> *One does not attempt to determine what a profession is in an absolute sense so much as how people in society determine who is a professional and who is not, how they "make" or "accomplish" professions by their activities.*
> *(Friedson, 1983)*

Consumers of midwifery services, alongside employers, professional bodies and government, continuously assess occupations generally using a traits process, providing opinion on which occupations qualify as professions, and determine what "professional power" is attributed to the professions, through the reporting and evaluation of services.

Meanwhile in the UK, Johnson (1972) considered the power approach from a different angle. He took account of relations between the consumer and producer within the sphere of professional services and studied who controlled the consumer/provider relationship and whom it benefited. It is only relatively recently that consumers have assisted in the direction of NHS services, and as a result the notions of choice, control and continuity (DH, 1993) have permeated maternity services. Johnson (1972) reconceptualised the idea that a profession is not just an occupation but is a means to controlling an occupation that is concerned predominantly with the concept of "power." This new critical theory of "power" and "profession" has remained central to the development of sociology and the professions throughout the last decades as the "power approach," appeared to fit better than either functionalism or the traits approach.

The professional project

Larson (1977) further developed the interactionist theme by weaving Marx's theory of the class system and its association with a power structure, and Weber's ideas around social stratification and its' economic and social order. Larson constructed a new concept, her intention being:

> To examine how the occupations we call professions organised themselves to attain market power.
> (Larson, 1977, p. xvi)

Larson claimed that a profession's autonomy is a privileged position and depends on the state to maintain its position, and also that the characteristic traits that define a profession are not assured in enabling professions to maintain boundaries and preclude membership. Furthermore, having gained autonomy, there follows a position of prestige independent of sponsorship. A backdrop of requirements for the project is provided by Larson, which includes a body of relatively abstract knowledge and market potential. Midwifery fits well with this concept, as it involves specialist knowledge that presents an opportunity for income – one that is subject to market control. Knowledge holders, or midwives as a group, in standardising their knowledge are able to control its distribution, and they are therefore placed in a position to be able to negotiate with the state (DH, 2004; DH, 2007).

The system of professions

Abbott (1988) favoured a more structural aspect when studying the sociology of professions. His examination of the work professionals "do" took the sociology of profession in a new direction. He observed the work of professionals, which led him to observe inter-professional competition and jurisdiction. In his study of professions at work, he shifted the focus from structure and power to the content of a profession's work, a phenomenon he termed "jurisdiction." He then attempted to analyse the systematic relations of the professions and the outside powers that affected the overall system. In examining professional work and claims over their jurisdiction within a social and cultural context, he noted that professions claimed "jurisdiction" over particular tasks, with tasks being defined culturally and socially; for example, childbirth professionals preside over different tasks around childbirth, but arguably professions can compete for "jurisdiction," hence creating professional competition. This is particularly significant to the present study, as it examines the boundary working of MSWs and midwives and explores the practitioners' perceptions of jurisdictional matters.

In conclusion, there is no singular concept to define what a profession constitutes, or indeed what is meant by "professionalisation," and yet we trust in professional expertise – doctors for our health, midwives for our births, accountants for our money, etc. However, there are facets

of these theories that resonate in constructing a profession and creating a professional. The process is made up of many principles, and I have endeavoured to identify how these principles have influenced midwifery in the twentieth century.

Professional closure

As previously discussed, sociologists have developed different theories around what constitutes a profession. It has been noted that since the 1902 Midwives Act, midwives have strived to retain control through the regulation and education of midwifery, in an attempt to enhance midwifery's credentialism (Kent, 2000). In addition, they have become increasingly concerned with maintaining their identity and legitimising the status of the profession. With this in mind, I consider the strategies of social closure and take into account the interplay of discursive strategies, particularly in relation to midwives.

Exclusionary closure is defined by Parkin (1979) as a mechanism of internal occupational control, whereby an occupation exercises its' power by monopolising the skills and knowledge of its' occupational group. In the case of midwives, they continue to monopolise normal pregnancy and birth processes and are seen to control the entry of potential candidates into the profession. Midwives have employed exclusionary closure in an attempt to elevate the status of the profession, midwifery courses are now degree-accredited, therefore placing emphasis on increasing theoretical knowledge, and whilst continuing to be practice-based they have shifted away from previous apprentice-type training. This process with Neo-Weberian roots is seen as "professionalisation" (Crompton, 1987; Kent, 2000).

Demarcationary closure is a concept introduced by Kreckel (1980), one which is concerned with inter-occupational control and the construction of boundaries between occupations. Whereas exclusionary strategies are used subordinately in vertically downward oppression, demarcationary strategies are applied horizontally and used to define the spheres of practice between professions and/or occupations, such as those between midwives, nurses and doctors. Midwives have defined their role and outlined their statutory obligations by differentiating themselves from doctors, and whilst they share many traits with nurses, they have at the same time strived to divorce themselves from their nursing colleagues. It has been highlighted by midwives that they oversee normal and natural pregnancy and childbirth as autonomous practitioners, whilst nurses, in comparison, focus on sickness and health and have remained under the control of the medical profession (Kent, 2000). Politically, midwives have found themselves caught in a dilemma, as their numbers are small, and they therefore acknowledge that collaboration with nurses is necessary to create a larger, more powerful force to gain political power in healthcare services, although this is also seen as weakening the midwifery profession and midwives' position in society. Similar to these inter-professional relationships, this study seeks to examine the roles and boundaries between MSWs and

midwives by looking at how they used demarcationary and jurisdictional measures to define their spheres of practice.

Inclusionary closure was developed by Witz (1992) and runs counter to exclusionary closure, as it takes into account those who were excluded, i.e. the "ineligibles," and considers how to change their eligibility to gain entry into the profession. How do they acquire the qualities required, or else influence the professional body or educational establishment to consider their application, for entry? An account of inclusionary closure in midwifery is provided by the women practicing midwifery before registration became statutory, and those that had no formal education but were able to provide a statement evidencing their good practice could be placed as "bona fides" on the midwives' register and become eligible to practice.

Dual closure is another form of social closure where occupations that have been excluded from another occupation attempt to establish their own distinctive area of practice, whilst at the same time employing their own exclusionary practices. As a result of experiencing other forms of social closure at the hands of medical men, midwives in the past chose to take on their own gendered professional project, earning them professional status and professionalising the role. It is noted that this is how an occupation becomes a profession. At the present time MSWs are carving out areas within which their own occupation can practice, a strategy that is comparable to the early experiences of midwives.

Patriarchy

The literal translation of the term "patriarchy" is "rule of fathers." Some theorists prefer to use the term patriarchy in this historical and specific form of male power within the family (Rubin, 1975; Barrett, 1987). With this in mind, it is thought that patriarchal systems developed alongside social systems, with anthropologists believing that our hunter-gatherer ancestors were of a more egalitarian nature. Some sociologists argue that patriarchy is an inherited genetic behaviour, rooted in the physiological differences between men and women that feature in all human cultures (Goldberg, 1973). Others oppose this biological theory in favour of a social one, whereby social and cultural influences are responsible in the creation of female and male gender roles, with these social constructions being passed down through the generations (Sanderson, 2001). There continues to be lively debate amongst sociologists as to the usefulness of the term, and in today's society in Britain, patriarchy is seen as a more complex subject taking a broader view of the issues involved. Sociologists seem to prefer to consider the wider social systems of gender relations in society of male dominance and female oppression and subordination, using the term patriarchy purely because there is no suitable alternative (Walby, 1990; Witz, 1992).

Private patriarchy

Private patriarchy is considered to be household-based. The patriarch – the husband or father – exerts control of the home environment, becoming both the oppressor and beneficiary, whilst the woman working within the household is exploited for her productivity around chores and child-rearing, and becomes the oppressed (Kent, 2000). In the past women were also subjected to exclusionary strategies such as being denied access to paid employment, the inability to inherit property (enforced through laws around male primogeniture) and subjected to suffrage, thus excluding them from the same rights as men. Private patriarchy was thought to be at its height during the nineteenth century (Walby, 1990), particularly in the middle classes, when domesticity within homes was at an all-time high.

Public patriarchy

Public patriarchy is termed in such a way as it originated in the public sphere of society, in work outside the home, within cultural society, in institutions such as hospitals and educational establishments. Women began to enter the labour market, albeit not on equal terms with men, and became subjected to occupational segregation in relation to the work they undertook together with their pay and conditions – a strategy that can be observed in present-day society and one that continues to discriminate against women. Walby (1990) identifies a historical shift from private to public patriarchy and was of the opinion that the nineteenth century was characterised by private patriarchy, as women stayed at home, whilst the twentieth century was a time of public patriarchy when women moved into paid work. However, Walby maintains that women remained subordinated to men in relation to the division of labour, both inside and outside the home throughout both eras. Not dissimilarly, and despite midwives having been awarded professional status at the beginning of the nineteenth century, they too continued to be subjected to public patriarchy by having limitations placed on their practices by medical men and the state.

Women's work

Historically, as I have discussed earlier in this chapter, midwifery was seen as "women's work", the "caring" element of which is regarded as something women do naturally (Kent, 2000). Pregnancy, birth and motherhood were also judged to be part of a woman's nature, and these processes were considered to occur within the private sphere of the home and family without any monetary remuneration, although sociologists maintained that housework and mothering were most certainly work (Oakley, 1974). Moreover, even though they were never allocated monetary values, in terms of labour market value these tasks were indeed valuable and added to the wealth of the economy. In contrast, men have been connected with production processes by earning a wage outside the home, within the public sphere of

society. Women, as mothers and daughters, were seen to be dependent on men for financial support. Women, who did work tended to be single remaining at home within the family unit - their wage an addition to the family income. Men were seen as the family wage earner, earning higher wages than women, even when employed to do the same job, as men were supported by employment, social and union policies underwritten by the state. Therefore, it did not make economic sense for men to stay home, as this incurred greater costs to the family and placed further restrictions on women going out to work (Hatt, 1997).

The labour market

As women entered the labour market they experienced a division of labour based on gender, as some jobs were deemed unsuitable for women and they were limited to the types of industries within which they could be employed; for example, in Britain women were banned from underground mining, as outlined by the 1842 Mines Act, and neither were they able to train as doctors until the mid-nineteenth century, and were met with further job segregation, as they were excluded from practicing as surgeons. In addition, well-paid jobs, together with jobs of high status, were difficult for women to access because of society's beliefs regarding what type of job a woman should undertake. Work pattern studies showed that women continued to be employed in low-paid, low-status jobs more so than their male equivalents (Witz, 1992).

Traditionally, nursing, midwifery and teaching were considered suitable jobs for women, which enabled them to live independently. In modern society, women were seen to 'crowd' (Kent, 2000) into these types of employment, as employers appear more willing to circumnavigate their domestic responsibilities. As recently as the 1970s, it was conventional for women to give up work when they married, and the idea of them continuing to work after marriage, particularly if they had children, was certainly frowned upon by society. Again, women were systematically disadvantaged, as they moved in and out of work for the purpose of childbirth and childcare and experienced difficulties in gaining promotion within the workplace. It was also noted that even in female-gendered jobs, for example nursing and teaching, men climbed the career ladder more rapidly to occupy higher status and more senior posts, a strategy recognised as 'vertical segregation' (Hugman, 1991). It has been argued that these patriarchal strategies rely on women's labour, which is effectively appropriated by men through exclusion in the home and segregation in the workplace (Walby, 1990).

Patriarchy and midwives

As previously discussed, midwifery knowledge remained with midwives until the Renaissance, when at which time medical men attempted to exert jurisdiction and develop their midwifery knowledge, by attending high-status women in labour and working down the social classes as

far as it was profitable, and simultaneously ousted midwives from their domain. As medical men increased their domination of the labour market, so it followed that the oppression of midwives increased. Earlier, the Church had subjugated midwives with their sworn oaths, licensing and mandating them with religious tasks, with the Church profiteering in claiming souls in life and death. Further exploitation of midwives' knowledge and wisdom occurred at the hands, or rather instruments, of barber-surgeons, although not all barber-surgeons were considered to be male (Towler & Brammall, 1986). Further subordination of midwives by men is evidenced through men controlling the education system, as women were deprived of equal rights in issues such as education and formal learning.

Midwifery was acknowledged as an occupation in agrarian society, but in the years preceding midwifery regulation, midwives exerted a dual closure strategy and used usurpationary and exclusionary strategies to evade and limit their domination by the medical establishment (Macdonald, 1995). An alliance of midwives formed the Obstetrical Association of Midwives and the Female Medical Society and by using revolutionary tactics they attempted to establish an area of practice and assert their independence to free them from the domination of medical men. These actions effectively disadvantaged and immobilised the midwives, as not only did they infringe on the jurisdiction of medical men, but also they did not have the support of any medical men. In contrast, the Midwives Institute campaigned for similar rights but used accommodative tactics that reflected the views of the Obstetrical Society of London, whereby midwives were deemed reliable to manage "normal" labour and birth but would know when to call upon a doctor's services should a labour or birth become "abnormal." The support of medical men was pivotal in gaining statutory rights and enabled midwives to take control of their training, registration and autonomy via their own professional body, although they found themselves faced with further opposition from medical men. The struggles with the medical profession had entered a new era, and midwives found they were presented with a new dilemma, as their practices were circumscribed and controlled by the medical profession through the Central Midwives Board; not one single midwife sat on the board, and they were reliant on one doctor to act as their representative (Cowell & Wainwright, 1981). The discursive practices (Witz, 1992) of the medical men ensured the engendering of professions. Midwifery was considered a female construct and midwives were allotted caring and normal roles, whilst medical men presided over anything abnormal that required any intervention of a surgical nature. More than a hundred years on, the positions of midwives and medical men have remained relatively static. The major difference nowadays is that birth has become more medicalised, as most women choose to birth their babies in hospital, a move which has resulted in the further subjugation of the midwives. Gender still remains an issue, as the majority of midwives are female, whilst most obstetricians are male and continue to use discursive practices to maintain their privileged status (Macdonald, 1995).

Conclusion to Chapter Two

Midwives, in pursuing their own professional project (Larson, 1977), have effectively earned their professional status, and in the process they have used social closure as a strategy for success. They have struggled against the discursive strategies of men, in the form of the Church, the state and the medical establishment, yet they cannot totally rid themselves of their subordinate role, as they remain within a patriarchal society. In tracing the history of midwives, I found sparse evidence of apprentice or trainee midwives and no evidence of assistants until the late nineteenth century. At present, and in view of what I have found, I consider that MSWs are in a position that is similar to where midwives were positioned before their pursuit of statutory regulation.

CHAPTER THREE

Theoretical Perspectives, Methodology and Methods

This chapter provides an account of the theoretical perspectives upon which this study is based. The supporting rationale for assuming a feminist perspective is reviewed and I consider my standpoint as the researcher in relation to this study. I also explore how taking a qualitative approach underpinned the research. A synopsis is given of the study's conception, and there ensues a discussion around its purpose. The methods used to collect and analyse the data are also outlined. Details of the issues that arose from employing interviews as a method of data collection are provided, along with those that occurred as a result of using Mauthner and Doucet's (1998) voice-centred relational method for analysing the data. There follows a discussion of the ethical issues that encompassed all parts of the study. Further consideration is given to the matter of me as a midwife researcher and the use of reflexivity. Tracy's 'Big Tent' model was used as the basis for the rigour of the study, and its' "universal markers" are examined and explained. In summarising this chapter the reader is once again reminded to reflect on the initial aims of the study.

Feminist perspective

Initial thoughts

As previously discussed in Chapter One, I began this study as a woman, a mother and a midwife and with an underdeveloped feminist perspective. It was only towards the end of the study, and on reflection, that I realised feminism had permeated the whole research process. Indeed, it is my own epistemology that influenced the formulation of the research question through to the reporting of the research findings and the final recommendations. I recognised I had moved away from objective, hygienic and androcentric research, opting instead to focus on the subjective, which has previously led to criticisms of bias and the danger of presenting uncritical, distorted research (Hammersley & Gomm, 1997). Reflexivity has been recognised to improve objectivity in feminist research (Hesse-Biber, 2012), so I therefore chose to disclose my values, attitudes and biases throughout the research process, in order to help balance the study. A dominant feature of feminist work is its political overtones (Kemp & Squires, 1997). As Kemp and Squires (1997) state, 'feminism's commitment to material and social change has played a significant role in undermining traditional academic boundaries between the personal and the political' (Kemp & Squires, 1997, p.4). At the point of analysing the data I realised that a feminist perspective could help me to contribute to knowledge in a meaningful way that would make a difference to the working lives of MSWs and midwives.

Feminism

When reviewing feminist perspectives it seemed logical to first ask "What is feminism?" I found many different definitions, with researchers debating the existence of either one or multiple views on the subject (Reinharz, 1992; Hoffman, 2001; Kingdon, 2009). Over the past 150 years in England there have been three distinct "waves" of feminism, the first of which emerged at the end of the nineteenth century. The first wave encompassed the movement of women's suffrage in the early twentieth century, whilst the second wave was considered to have come about at the beginning of the 1960s and was associated with campaigning for women's civil and legal rights. There is scholarly debate that a third "wave" started in the 1990s (Kingdon, 2009), continuing the aim of the second wave aimed at ending discrimination against women. Feminism can be defined as an ideology and a social movement concerned with gender and improving the lives of those disadvantaged by gender inequality. Wood (2005) states that feminism means 'different things to different people', which may account for the many permutations (for example, Chicana feminism, Black feminism, Christian feminism, ecofeminism) that are proposed to exist, each placing emphasis on particular parts of women's lives, which helps to define one type of feminism from another. In considering the issue of one unified form of feminism, Heidi Mizra (1997) makes the point in relation to black feminism that 'you can have difference with a conscious construction of sameness' (Mizra, 1997, p.2), whilst Bulbeck (1998) argues that in pursuing the differences between feminisms 'we are in danger of losing sight of commonalities and connections between women' (Bulbeck, 1998, p.56). Essentially, I would argue that feminism is concerned with the oppression of women and is a movement towards their greater equality and freedom.

In the wake of feminism, feminist theory developed. I present the four main theories related to feminism as outlined by Jagger (1983), namely liberal feminism, Marxist feminism, radical feminism and socialist feminism, and I discuss their connectedness to this study. Chronologically, the earliest known form of feminism was liberal feminism, which was concerned with the emancipation of women and gender equality (Tong, 1998) and focused on achieving equal rights for women in private and public life spheres. In the private sphere this meant striving for equal partnership in marriage and childcare, while in the public domain it involved equal access to education, equal pay for equal work and equal political rights. Parallel to the oppression of women in patriarchal society, midwifery has been subjected to similar experiences by medical men, the state and later the hierarchical structures of the NHS, as discussed in Chapter Two. Liberal feminists tended to be dependent on the state (Rogers, 2005) and institutions for supportive legislation, and working within these patriarchal systems may have placed them in a disadvantaged position. Indeed, this study can be seen as being rooted in liberal feminism, as MSWs and midwives have remained dependent upon these organisations for the terms of their employment, policies and guidelines in the workplace, which in turn affect their everyday practice and working relationships.

Marxist feminism considers that women's subjugation stemmed from the development a capitalist society and the class system (Kralik & van Loon, 2008). As such, women's oppression was accorded to their position in society, with men controlling industrial and sexual labour within the home and in society. In relation to this theory I perceived the MSWs and midwives to be the proletariats and the structures of society (the NHS and the state) as the bourgeoisie, which legitimised further the subordination of women in a capitalist class system through social control of childbirth and its policies.

According to radical feminists, the subordination of women is rooted within patriarchy and focuses on the social dominance of men over women, and it is seen as a primary cause of women's oppression, as discussed in Chapter Two. A critical component of patriarchal theory is the relationship of dominance, where one group prevails over another group and exploits this group for the dominant group's own gain. The tenets of radical feminist theory were apparent in this study, with the MSWs and midwives attempting to assert their roles and relationships within the confines of the patriarchal establishment where they were employed (the NHS). Furthermore, it is Tong's (1998) understanding that radical feminists (women oppressed by the patriarchal society) in the past ran the risk of 'doing unto others that which they do not want done unto themselves and other oppressed groups' (Tong, 1998, p.88); in other words, the oppressed became the oppressors. Effectively, by characterising midwives as radical feminists, in this study the MSWs became the oppressed and the midwives their oppressors.

Socialist feminism emerged in the 1970s and braided together strands of radical and Marxist feminism, partly in terms of patriarchy and partly in terms of exploitation in a capitalist society. This study draws upon this final orientation of feminist theory. Patriarchal structures persisted between midwives and the medical profession, as discussed in the previous chapter and yet the MSWs found themselves subjugated by the professional closure practices of the midwives (refer to p.31) and effectively became the oppressed.

Feminist epistemology

Epistemology is concerned with the nature of knowledge, its sources and the limits of what can be known by the knower. Social epistemology is about understanding from a social perspective, knowledge discovery, knowledge creation and knowledge production, and it aligns with Harding's (1987) theory, whereby an epistemology is 'the theory of knowledge'. Feminist epistemology is concerned with 'whose knowledge' is being considered and how knowledge has been constructed by the knower from a gender perspective, taking into account situation and context. This moves away from traditional epistemology and its androcentric roots that accounted neither for women's experiences nor their perspectives – in effect neglecting, ignoring and/or overlooking women's ways of thinking and knowing (Stanley & Wise, 1983; Belenky, 1986). Nonetheless, feminists have not been without their struggles in exposing this masculine bias, and as Longino (1997) remarks, 'the idea of feminist epistemology throws some philosophers into near apoplexy' (Longino, 1997, p.19). Harding

(1987) proposed a tripartite framework to differentiate between the different strands of feminist epistemology, namely feminist empiricism, feminist standpoint epistemologies and transitional (postmodern) epistemologies. However, these three epistemologies have been criticised, as they are unable to reflect adequately all types of feminist research (Haraway, 1991; Reynolds, 2002; Smith, 2005). In due course they have been superseded by the processes of "knowing," "knowers" and "known" (Hawkesworth, 1989), and they equate roughly to 'How do we know what we know?' (Alcoff, 1998), 'Who can be the knower?' (Code, 1991) and 'What can be known?' (Alcoff, 1998).

It is important to recognise that there is no-one way of knowing, as knowledge is context-based and reflects each individual's own location in relation to the topic being researched (Kralik & van Loon, 2008). Feminists have argued that gender influences understanding, and revolves around the idea of situated knowledge. There is also the notion that constructed knowledge and beliefs are the result of social context, and as Harding (1993) states, 'knowledge claims are always socially situated' (Harding, 1993, p.54). This is particularly the case in this study, as the MSW and midwives' experiences can be seen as socially situated and draw upon their individual epistemologies to reflect their own location in relation to their working relationships. The "knowers" in this study are the MSWs and the midwives, but whilst they are all women, they are also two distinct working groups. According to Longino (1990), 'communities, not individuals "acquire" and possess knowledge' (Longino, 1990, p.14); therefore even though the MSWs and midwives "acquire" and "possess" their individual experiences, their collective knowledge is attributed to their identified group – all the while remembering that not all female experiences are homogenous (Kralik & van Loon, 2008). In essence, the knowledge of the MSWs is credited to the MSW group, the same being true for the midwives. The notion of 'What can be known?' is the aim of this study and is to be found in the data within Chapter Four, which highlights the most significant findings.

Whether or not feminists need their own epistemologies is an ongoing argument, the main justification being to enable women's lived experiences to be viewed through a feminist lens, and until new theory emerges to replace the old there will remain a status quo with arguments for and against a feminist epistemology.

Feminist research

In answer to my next questions, 'What is feminist research?' and 'How does it different from other research?' feminist research places gender at the centre of the research process. Furthermore, it has been conceptualised as research "for" women and "with" women rather than "on" women (Hall & Stevens, 1991; Webb, 1993; Olesen, 1994). Traditional approaches have dominated the world of social science research and employed masculine perspectives on research design, methods, data collection and analysis (Smith, 1974; Edwards, 1990). They have been criticised for being 'malestream' (Stanley & Wise, 1983, p.12), relating to a social world defined by men and discriminating against women in terms of gender blindness, thereby overlooking their voices,

experiences and everyday lives. Feminist research challenges these previously accepted claims of knowledge by asking 'new questions that place women's lives and those of other marginalised groups at the centre of social enquiry' (Hesse-Biber, 2012, p.3), thus unearthing subjugated knowledge whilst effectively disrupting traditional ways of knowing. Moreover, feminist research aims to illustrate women's experiences framed within their contexts and language (DuBois, 1985; Speedy, 1991).

Feminist researchers reject the idea that feminist research is by nature value-free (Haig, 1997), and they consider they are unable to separate themselves entirely from the world within which they live, their values or opinions. Therefore, feminist researchers have moved away from using traditional positivist research in the belief that complete objectivity cannot be achieved (Harding, 1987; Fonow & Cook, 1991); indeed, Letherby (2003) states that they should 'not only acknowledge this but celebrate it' (Letherby, 2003, p.6). Letherby (2003) also claims that there is a certain amount of 'messiness' included in the processes of undertaking subjective-based research, and as a novice researcher I certainly found this to be the case – I found myself navigating around my different identities as an inside/outside researcher, much like Trinh (1991), as well as negotiating my ethical duty around decisions to place the voices of MSWs and midwives in the public sphere, similar to Mauthner & Doucet (2008).

As feminist researchers we are reminded to pay attention to the notion of reflexivity, 'a process whereby researchers recognise, examine and understand how their social background, locations and assumptions affect their research practice' (Hesse-Biber, 2012) and which is considered a key facet of undertaking feminist research (Hesse-Biber & Leckenby, 2004). Therefore, as the researcher, I aimed at providing an open and reflexive account about how I approached and carried out the study, discussing my own location within the study and stating my biases and their influence. My intention was to enable others who read my work to understand the background to the knowledge I would be co-producing and to make credible the claims I would be making (Letherby 2003).

More importantly, rather than defining what constitutes feminist research, Reinharz (1992) considers it is more important to focus on what is included in the research. This study as a piece of feminist research focuses on social issues viewed through a female prism (Cook & Fonow, 1990; Fonow & Cook, 1991), effectively capturing the lived experiences of MSWs and midwives and enabling their voices to be heard, to 'wake us up' (Hesse-Biber, 2012, p.5) to the hidden subjugated knowledge of these marginalised groups of women. Moreover, Wise (1987) is of the opinion that feminist research should be 'concerned with women's oppression', and certainly the MSWs and midwives can be considered a marginalised group, as not only are they all women but they also work within a patriarchal establishment.

Is there a feminist method? Is there a feminist methodology?

I found as the researcher a certain lack of clarity around the terms "method" and "methodology," and as Letherby (2003) also notes, they have often been misunderstood and confused. However, Harding (1987) provided an understandable definition and distinguished between them, considering a method as a 'technique for gathering evidence' and a methodology as 'a theory and analysis of how research does or should proceed'.

In addressing the question as to whether there is a distinct feminist method, the answer is a resounding 'no'. Any method can be used in feminist research, with Holloway and Wheeler (1996) recognising that feminist research can use the data collection and analysis processes of existing methods. Similarly, in her review of feminist research, Reinharz (1992) provided an itinerary of methods that can be employed.

The methodology is much more philosophical and value-laden, so much so that Cook and Fonow (1986) consider it 'a complex, abstract and often elusive concept' (Cook & Fonow, 1986, p.2). As to whether there is a specific feminist methodology, there is no definitive answer and debate continues amongst feminist writers about its existence (Stanley & Wise, 1983; Fonow & Cook 1991; Hesse-Biber 2012). Feminist writers in support of a feminist methodology argue that it emerged as a result of searching for a methodological approach to feminist research (King, 1994); they take the view that it is rooted in feminist theory and draws upon feminist epistemology (Oakley, 1981; Stanley & Wise, 1983; Harding 1987). Letherby (2003) suggests 'there is a feminist approach to thinking methodologically' (Letherby, 2003, p.5), and in defining epistemology as a theory of knowledge production she considers that reflecting methodologically 'is itself an epistemological act' (Letherby, 2003, p.5).

Biases

When undertaking feminist research it is important that the researcher identifies biases (King, 1994). Furthermore, I consider it valuable to understand the premise on which this study was undertaken, as it goes some way towards understanding its influences on the subjective interpretation thereof. I have already identified myself as a feminist and found trying to locate myself within feminism to be difficult task. I draw upon different feminist theories, depending upon where I am located at any one time, and I do not subscribe to any particular theory; instead, I characterise myself as possessing an eclectic mix of feminism traits, as outlined earlier in this section.

Another of my predispositions concerns the research question, and the matter that female researchers often start with a research question that is linked to their own experience (Reinharz, 1992), which is certainly relevant to this study, as I shall explain. Before beginning this study I had searched with difficulty for a subject to investigate, and in writing this chapter I puzzled over whether my own mother's experience may have subconsciously influenced my ultimate decision. My mother

had worked as a nursing auxiliary whilst I was growing up, and frequently referred to herself as being 'partially' nurse-trained, having been required to abandon her training in order to marry and raise a family. I questioned whether this study was in part remuneration for her loss. I provide this explanation, as it offers an insight into one of my epistemologies, made evident by referencing and discussing State Enrolled Nurses in Chapter Two.

Paying attention to how researcher assumptions and agendas affect all parts of the research process is in effect practicing reflexivity (Hesse-Biber & Leavy, 2007), and a subject I shall discuss later in this chapter (p.61).

Power and influence

Feminist research is considered interactive and non-hierarchical (Keddy, 1992), yet researchers are likely to be more highly educated, assertive and articulate than the people they research (Wise, 1987; Ribbens, 1989; Webb, 1993). Furthermore, it is the participants that are approached to become involved in the research, which effectively places the researcher in a more powerful position (Webb, 1993). Another concern that is highlighted in feminist research is the participant-researcher relationship, and the ability to report adverse findings (Wise, 1987; Webb, 1993), a concern that featured in this study and is discussed in Chapter Five.

In terms of the power relations that exist between the participant and researcher, Oakley (1981) is especially critical of the interview process and considers interviewing, particularly interviewing women, a contradiction in terms, recognising that the interviewer retains control over the interview whilst asking questions. However, the participant retains control of their private knowledge, relinquishing control during the interview by answering questions, an action that may be seen to invoke a sense of powerlessness and vulnerability in the participant. Oakley (1993) advocated the nurturing of a reciprocal relationship between the interviewer and participant to prevent them from becoming passive respondents to directed interviewing. Likewise, the interview should not form the basis of a psychoanalytical interview facilitated by non-directive interviewing. Listening to and valuing individuals and their ideas are intrinsic not only to midwifery but also to the caring professions, whilst exchanging information can be invaluable in generating trust and willingness to share thoughts and ideas. The adoption of a sharing and non-hierarchical approach is viewed as an essential component of feminist research (Webb, 1983, Finch, 1984); therefore, I approached the study with a thoughtful awareness, having recognised that the MSWs and midwives had been approached collectively and in a manner that denied them the power to refuse to participate. I aimed at counteracting this initial recruitment approach by explaining the study and the process to potential participants and negotiating access and consent by approaching them individually. In addition, I provided the participants with verbal and written information (participant information sheet Appendix 1) about the study, and I requested their written consent (consent form Appendix 2) to be involved. The participants were also informed that they could withdraw their consent at any time throughout the duration of the study. Furthermore, after

the pilot interviews, I abandoned the structured type of interview (Appendix 3 & 4) in favour of a semi-structured interview and devised a series of topics that covered the aims of the study (Appendix 5 & 6). This enabled the MSWs and midwives to take partial control of this conversational interview and allowed us to cover the salient points and spiral between the topics of the study, an example of the feminist perspective supporting this study.

Me, myself and others

I have chosen to write in the first person, and moved away from a traditional academic style of writing as it has been argued that it reflects distance and objectivity (Morley, 1996). However, as previously discussed, I am a feminist and a researcher, and I also hold responsibility for and political commitment toward what I write. The point regarding what language we should use when referring to people who have agreed to be involved in the study is raised by Letherby (2003). For instance, what term should I use to refer to the people in this study? Ought they be referred to as "subjects," "the researched," "respondents" or "participants"? "Subjects" infers that these people are part of a state and are being subjected to the research, thus implying they have no control. "The researched" is of a similar ilk as the previous term. "Respondents" assumes that these people are involved by way of answering questions, but the term offers no indication of any reciprocity between them and the researcher. "Participants" appears to be a more suitable name, as it implies there is a reciprocal relationship between the person agreeing to be involved in the research and the researcher, and furthermore it indicates that a participant has some control over the research process. However, it is also problematic in the sense that it gives the impression that the researcher maintains overall control over the process and that an imbalance of power exists in the relationship. I aimed at being mindful of the language and terminology used, recognising that language is a way of tempering the hierarchies of power and authority in the research process (Smith, 2005; Hesse-Biber, 2012) – a phenomenon I consider further in this chapter when discussing Mauthner and Doucet's (2008) voice-centred relational method.

Consequently, I chose to use the final title of "participant," but wherever possible I have replaced the term with the true title of the participants, namely MSWs and midwives, reflecting more accurately who they are and what they do, which is seemingly more contextual. My feminist approach to the research means I have chosen to write reflectively and shown my personal involvement with the research. Weber (1949) was one of the first writers to include himself in his research, as he recognised that the researcher's personal and political values affect the research process and argued that social scientists need to make clear their own values and opinions to help minimise possible biases. These resonances of self are recognised as being inherent in feminist work (Roberts, 1981; Stanley & Wise, 1993; Letherby, 2003), as we need to know our own location within our work and make it clear in our writing, for the reasons I have already outlined.

Summing up feminist perspective

This research began as a study framed within a feminist perspective. I have discussed some of the theories of feminism and also offered an insight into various outlooks that influence women's oppression. However, the feminist perspective is not about viewing the '"woman as a victim" of their circumstance; instead, it celebrates diversity and varied strengths' (Maguire, 1996, p.107). Using a woman-centred approach assists in revealing the previously subjugated knowledge of the MSWs and midwives. This new knowledge, when placed into the public sphere, transforms their personal struggle into a political one, enabling the voices of these marginalised groups to be heard. In addition, the use of a feminist perspective enables the lived experiences of the MSWs and midwives to be highlighted, grounded by their frame of reference, experiences and language (DuBois, 1985; Speedy 1991).

However, unearthing new knowledge needs to extend beyond knowledge discovery and creation. Feminist research has a political commitment to social justice (Drevdahl, 1999) and carries an obligation to affect social change by assisting in and improving the lives of women (Hall & Stevens, 1991). One of the objectives of this study includes providing recommendations for practice, with the aim of improving the lived experiences of the MSWs and midwives working together (presented in Chapter Six).

Qualitative approach

Qualitative research is considered to be an approach based on naturalistic enquiry, examining phenomena that occur in their natural environment and where a variety of methods can be used to analyse and interpret such occurrences and give meaning to them. Lincoln and Guba (1985) present naturalistic enquiry as an alias of qualitative research, and they define that 'naturalistic investigation is what the naturalistic investigator does' (Lincoln & Guba, 1985, p.8). This study was based primarily on the views and experiences of the MSWs and midwives who were involved in the integration of MSWs into community maternity services. It enabled me as the researcher to study them in their natural social setting, and it offered the opportunity to examine social phenomena in the "field," assisting in the exploration of 'things that matter, in ways that matter' (Mason, 2002, p.1) and offering an insight into the meanings that the MSWs and midwives lent to their social world.

Furthermore, qualitative research is regarded as being person-centred and holistic, as it can be used to study people's actions, perceptions and emotions. This study investigated the thoughts and perceptions of the roles and relationships between the MSWs and midwives, and it also examined how they acted towards things on the basis of the meanings that things had for them, such as each the other's role and the situations they encountered as individuals in their daily working lives. This type of research focuses on human beings within their social and cultural contexts and 'enables the texture and weave of everyday life to be examined' (Mason, 2002, p.1), as such phenomena are

difficult to reach and attain using quantitative methods. Demonstrable advantages of qualitative research include being able to produce rich and detailed information and to discover the significance of the meanings they generate. Moreover, it enables the exploration of the meaning of such things that were derived from, or arose out of, the social interactions of the MSWs and midwives.

Human and health sciences have had a long and distinguished relationship with qualitative research (Holloway & Wheeler, 1996) and have been used to answer important questions posed within the healthcare system regarding the organisation and culture of healthcare providers, as these methods are considered more appropriate for studying such phenomena (Robson, 1993; Cluett & Bluff, 2000). Some authors suggest that another reason for choosing to use qualitative research is that it can serve as a useful tool when attempting to reveal processes that occur beneath events taking place on the surface, where there is little known about the area of study (Holloway and Wheeler, 1996; Mason, 2002). This is particularly relevant to this study, as the preliminary review of the literature uncovered very few qualitative studies relating directly to the relationships between MSWs and midwives. A further review of the literature revealed that any relevant studies thus far appear to have concentrated on the organisation and scope of work that MSWs undertake – an issue discussed in Chapter Two.

There are many valid reasons for undertaking qualitative research, and Corbin and Strauss (2008) provide a further rationale for taking a qualitative approach in this study, as according to them certain disciplines gravitate to a form of research that usually aligns with their discipline. Health science researchers have come to depend on qualitative research when studying people and their behaviours in the world in which they exist. In addition, Corbin and Strauss (2008) consider that where the investigator has a preference for and/or experience of a certain type of research, this affects the investigator's decision to choose an appropriate research approach. This reasoning seemed particularly apt for me, as I had had experience of taking a qualitative approach in previous research studies. Furthermore, as a midwife I considered pregnancy, birth and motherhood sociological events, and not purely science or medically-based occurrences, and therefore required an approach congruent with midwifery's sociological history. Midwives have struggled to remove midwifery practice from the medical sphere, away from the interference of medical men (Donnison, 1977), in a bid to liberate it from the clutches of scientific-based research. This is highlighted by the plethora of qualitative research that exists around midwives, mothers and birth (Cluett & Bluff, 2000).

Previously, there have been misconceptions regarding the logic of qualitative research. It has received criticism for being anecdotal and illustrative (Bryman, 1988; Silverman, 2004). Qualitative researchers have had to build a reputation to ensure that this approach is taken seriously and is equitable to quantitative research. A paradigm shift has been observed where the traditional views of natural science were originally criticised by natural scientists. Currently, interpretive perspectives have been revived and qualitative research has gathered momentum, evidenced by the increase in the number of published qualitative studies (Crozier & MacDonald, 2009).

Selecting a focus

The focus of this research was current to my own sphere of midwifery practice as a community midwife. It had relevance to my working practice inasmuch that MSWs were employed within the community midwifery service where I worked. Previously, I had worked very briefly alongside MSWs, a short-lived experience which enabled me to observe the introduction of the new MSW role into a community midwifery workforce. This influenced the research in two ways. Firstly, it assisted in selecting a focus for this study; secondly, having conceived an idea for a study, it enabled me to start my research journey. Mason's (2002) work notes that researchers often search out studies with subject matters that are relevant to their everyday lives and which bring about meaningful consequences. She perceives the relationship between the researcher and their research as seeking to define and understand issues that are significant to them I recognised that the subject I had chosen to study held significance for me, not only as a practitioner and my field of practice, but also through personal early life experiences, as discussed earlier in this chapter. Similarly, Neuman (1994) suggests that researchers choose their focus because of its relevance to personal values, everyday life, topics of current interest and the likelihood of locating funding. Again, this latter reasoning resonated with this study, as MSWs were a new addition to the NHS workforce and therefore a topical area for research as the study commenced. Furthermore, Robson (2002) states that 'all enquiry involves drudgery and frustration, and you need to have a strong interest in the topic to keep you going through the bad times' (Robson, 2002, p.49). Therefore, I needed a subject matter to sustain my interest and motivation throughout the lifetime of the study – a recommendation I found to be fundamental in the completion of this study.

Purpose of the study

According to Hansen (2006), the purpose of the inquiry may define the type of research undertaken, namely descriptive, explanatory, applied or evaluative. She asserts that researchers have specific fields of interest and expertise. Undertaking descriptive or explanatory research contributes to existing knowledge, applied research is designed to gain knowledge to solve a problem, whilst evaluation research is undertaken to assess the effectiveness of the implementation of a program or at its conclusion to make an assessment against its identified objectives. Moreover, Hansen (2006) considers that descriptive and explanatory research is carried out predominantly by academic researchers and students. This study appears to dissect Hansen's definitions, as it began as an explorative study of the relationships between MSWs and midwives, and as a piece of feminist research it can be viewed as descriptive and explanatory. It highlights the personal struggles of the practitioners and assumes their political struggle, striving to search for answers; therefore it may be construed as applied research. The study may also be defined as evaluative research as it aims to provide recommendations for practice to improve the working lives and experiences of MSWs

Furthermore, Anderson and Arsenault (2001) classified descriptive research as either historical – what has happened – or contemporary – what is happening – and identified these as basic requirements in the pursuit of knowledge. Conversely, explanatory research asks "what" is causing this to happen (Anderson & Arsenault, 2001, p9). In this study the descriptive research aspect was provided by the MSW and midwives' voices, thoughts and experiences, whilst the explanatory research element was undertaken through policy research, data collection and data analysis.

In response to the sparsely published research, this study commenced with the purpose of adding to the bank of existing knowledge and increasing understanding of the relationships between MSWs and midwives. Indeed, identifying the purpose of this study effectively helped in its design.

Pilot study

Prior to the main study, a pilot study was undertaken for a number of reasons. This involved interviewing an MSW and a midwife in separate interviews. The pilot, a mini version of the larger study, enabled me to check out of the sampling strategy (see p.50) planned for the larger study, to test the proposed interview schedule, to corroborate that the MSWs and midwives easily understood the research questions and that these did not include any ambiguities, and to ensure that the questions flowed naturally and did not hinder the interview process. Finally, it provided the opportunity for me as the researcher to practice my interviewing skills, as it had been some time since I had undertaken a research interview.

The Trust managed hospitals in two neighbouring counties, each with its own separate midwifery service. One Head of Midwifery (HoM) managed both midwifery services. The MSW chosen to participate in the pilot study was identified for two reasons; firstly, she had recently moved from the main study area into the midwifery service in the neighbouring county but remained under the jurisdiction of the Head of Midwifery; secondly, this MSW had pioneered the MSW service in the main study area and was therefore able to provide an account of her own experiences as an MSW working alongside midwives in the main study.

The MSW was approached informally via telephone, explanations of the study were provided, initial verbal consent for inclusion in the study gained and a meeting time arranged (written consent was obtained directly before the interview actually commenced). At the suggestion of the MSW it was agreed that the interview would be held in a local children's centre at a mutually convenient time, being both a familiar and comfortable setting and one that fitted into her working schedule. Creating an environment that was comfortable for the participant provided an environment that encouraged the MSWs and midwives to offer information during their interviews (Green & Thorogood, 2004). Moreover, agreeing to the MSW and midwives' terms enabled them to maintain partial control over the process, which in turn assisted in redressing the power balance. This was the beginning of the participant and researcher relationship, the importance of which in interviewing is a feature highlighted

in Oakley's (1981) work and remains a central issue of feminist research, as discussed earlier in this chapter (refer to p.43).

Selecting a midwife for the pilot study proved to be more difficult. The midwifery service in the main study area was divided into five areas; four areas-each employing one full-time MSW. The fifth area had had experience of an MSW in the team; however, the MSW had been moved to another area, so consequently the fifth area did not employ an MSW at the time of the study. In addition, it was also the area where I worked as a community midwife, and I grappled with the task of choosing a midwife to participate in the pilot, as I considered them to be both colleagues and friends. Alternatively, I considered the situation to be advantageous, as there was a pool of midwives that could be drawn from for inclusion in the study. Similar to the recruitment of the pilot MSW, I approached one of the midwives, who subsequently agreed to take part in the study. Several options were discussed before deciding that she would visit me in my home to undertake the interview. This not only enabled her to document the visit as an official visit in her daily practice, but it also reduced the risk of interruption by co-workers. Addressing the balance of power in this scenario was a little more precarious. Certainly for me there was a see-sawing of emotions as the researcher – I was pleased that the pilot study was going ahead, but nevertheless uncomfortable that it was to take place in my home. This was not because the midwife was unwelcome; it was more a case that I anticipated the discomfort of the midwife being interviewed within the researcher's environment.

As a consequence of the pilot interviews I changed the format of the interview schedule, as the questions were too well-defined and too numerous, and as a result they disturbed the flow of the conversation because I found myself reading and re-reading the questions throughout this time to ensure I captured the data that the schedule requested. Consequently, this set of predetermined interview questions was replaced with a set of topic areas to be used in the main study.

Gaining access

It was a requirement of the Trust's Research and Development department that permission from the researcher's interdepartmental manager be acquired before the commencement of any research study. Another crucial element was gaining approval from the Local Research and Ethic Committee (LREC), which is discussed later in this chapter. Therefore, I sought permission from the Head of Midwifery, who agreed to support my application for the study and suggested I took the opportunity to approach the MSWs and midwives as a collective group and provide an introduction and background to the study. The approval and support of the Head of Midwifery was key in gaining access to the potential participants; however, I was acutely aware that this same approval and support could also be construed as coercive in recruiting potential participants, and I was also conscious of the possibility that the MSWs and midwives would feel pressurised into taking part in the study, especially in view of the existing power differentials between them and the Head of Midwifery. As a consequence, I

realised this first meeting would be pivotal in capturing their interest and engaging them in the research process, and so I approached the group in a sensitive manner.

Recruiting to the main study

A date was arranged to introduce and discuss the planned study with the community MSWs and midwives at a community meeting. I recognised that the group I addressed were not only colleagues and peers, but they were also potential participants in the study and this was my first encounter with them in my dual role as midwife and researcher. I address this insider/outsider perspective later in this chapter (refer to p.60); nonetheless, at the time, I realised that securing the commitment and co-operation of this cohort was vital for the study to proceed: in my field notes (Field notes, p.14) I posed the question, "What if they don't want to do it?" referring to their (un)willingness to take part in the study.

At the meeting, an overview of the study was provided which outlined the purpose of the study and their involvement, focusing on the potential benefits that the study may provide in the future for themselves and the maternity service within which they worked. As the interviews were to take place in work time, I emphasised that as the researcher I would endeavour to disrupt their working lives as little as possible and aim to work around their needs and commitments to the service. I emphasised that their decision to take part in the study was voluntary, confidentiality would be maintained throughout and that they would remain anonymous through the use of pseudonyms.

This preliminary meeting enabled the MSWs and midwives to ask questions about the study and of me as a midwife and a researcher. Some MSWs and midwives approached me at the end of the meeting to ask further questions about the study. These revolved around what type of questions would be included in the interviews, how I would select participants and who would receive copies of the completed study. Some of these answers had been provided in the initial discussions highlighting that some of the MSWs and midwives remained anxious about the study.

Sampling

As I learnt of the different sampling practices I recognised that the ones I had used in the study combined a mix of data sampling techniques. Purposeful sampling was used initially, whereby MSWs and midwives who had knowledge (and experience) of the phenomenon under investigation were targeted for recruitment to the study. At the beginning of the study, four MSWs were employed in the community of one hospital. Therefore, all four were targeted for inclusion in the main study. The matter of the small numbers involved was an issue debated at length by members of the LREC, who argued the point that should one or more of the MSWs decline to be included in the study, the proposed study would become invalid. At the time, I was a novice researcher and had yet to increase my knowledge around sampling; therefore I was unable to engage in a meaningful argument and I

thus felt obliged to agree to their terms and conditions, and therefore the study would not proceed unless all the midwifery supports workers consented to take part in the study. However, in terms of qualitative research, there is no upper or lower limit to the number of participants, as it is concerned with acquiring rich and detailed data and not with the numbers involved (Sandelowski, 1986). In due course, all four MSWs agreed to be included in the research in the main study (excluding the pilot MSW).

Following the initial part of the sampling process, snowball sampling was employed whereby the first participants (the MSWs) were used as informants to identify the next participants (the midwives). The midwives selected had knowledge and experience of working closely with the MSWs. Snowball sampling is considered a particular type of purposive sampling and is driven by the emerging theory from data collection and analysis of the theory. Therefore, selecting the participants was part of the function of the emerging theory and impacted on sample size. Six midwives were selected to participate in the main study (excluding the pilot midwife).

Interviewing as a method of data collection

Conversation is considered a basic form of human interaction. This interaction between human beings enables them to share and exchange information, whereas interviewing is a specific type of conversation between an interviewer and an interviewee with the potential of producing knowledge (Kvale, 2007). Interviews have been used extensively as a method to collect data in qualitative research (Morse, 1991; Denzin & Lincoln 1998) and can take many forms. Duffy et al. (2002) list fourteen different types of interview when considering which is most appropriate to use in research studies.

At the beginning of this study I proposed to use one-to-one, face-to-face interviews with the participants as the method of data collection. A requirement of the LREC was the provision of an interview schedule (see Appendices 3 & 4) outlining the questions I intended to ask the participants. Initially I drew up two individual interview schedules – one to be used with the MSWs and the other with the midwives. They were not hugely dissimilar, and most of the questions mirrored each other; however, the LREC requested that the interview schedule for the MSWs should totally reflect the questions for the midwives. Consequently, the version 1 schedules (see Appendices 3 & 4), were amended accordingly and version 2 subsequently approved (see Appendices 5 & 6).

Practically, the pilot study highlighted several issues of using structured interviews. Notwithstanding my own narrow experience of interviewing, I found that the interviews did not flow like a conversation, and they actually felt unnatural and wooden. Referring to the schedule during the interview interrupted the course of the conversation, and addressing all the questions on the schedule posed an endless and arduous task. The interview schedule neither allowed for originality nor permitted any new phenomena to be explored, due its rigid agenda. The rigid set of questions limited the scope of the

study and detracted from its qualitative approach. Furthermore, this design did not help the negotiated process of reflexivity between the researcher and participant – a feature of taking a feminist approach.

Following the pilot study I discussed my experiences with my supervisors, modified the design of the main study, exchanged the structured interview schedule for a semi-structured model and developed an interviewer's guide that focused on the aims of the study (see Appendix 8). As the interviewer, I used the guide to open and direct initial questioning, listening to the MSWs and midwives recounting their experiences, a factor that is key in accessing rich and meaningful information (Kvale, 2007). Having a list of topics available, as suggested by Fielding (1994), which could be used in any order, and being free to phrase the questions in any way, certainly helped avoid the stiltedness of the pilot interviews. Consequently, I led the interviews with an introductory general question and some initial opening questions. Thereafter, I had a list of topics to which I could refer (see Appendix 8), and this flexibility enabled issues to be clarified and others that were significant to the MSWs and midwives to be explored further.

Emerging data from an interview is dependent on the craftsmanship of the researcher/interviewer. The conversation relies on the interviewer constructing a social relationship with the participant. Kvale (2007) refers to the skilled interviewer as having the 'ability to create a stage' (Kvale, 2007, p.8), enabling the participant to discuss freely and safely the phenomenon being studied; otherwise, the interview may only produce common opinions and prejudices. This point was particularly poignant for one MSW, as I found at the close of her interview when the recording of her conversation ceased, that she chose to disclose her most personal experiences regarding her role, thus indicating her discomfort in revealing her private inner thoughts and feelings. From my field notes I noted her explanation for withholding this information was that 'it seemed like she was dipping her toe in the water and testing out what the study was about' (Field notes, pp.22-24) and that she was also 'checking out her own vulnerability around her information remaining confidential' (Field notes, pp.22-24).

Fog (2004, cited in Kvale, 2007), a therapeutic researcher, compares the interviewer's ability to get inside a participant's defence systems to that of a Trojan horse, influencing the disclosure of knowledge or emotions that the participant would have preferred to remain undisclosed. Research interviewing has also been compared to therapeutic interviewing, as each possesses similar features (Collins, 1998; Dickson-Swift, 2006). Kvale (2007) identifies that research interviewing may lead to a therapeutic relationship developing between the participant and the researcher, and I was placed in this predicament on two occasions in separate interviews. In the initial part of my research, preparations had been made in anticipation of such an eventuality, whereby the MSWs and midwives could voluntarily access confidential professional counselling should they feel it necessary. Indeed, as the researcher, I was morally bound to ensure that the two MSWs to whom I refer were offered this opportunity at the close of their interviews.

The practicalities of undertaking each interview were considered, and a checklist drawn up (see Appendix 7) which assisted in planning and undertaking each interview. It also ensured that I complied with the LREC requirements by providing the MSWs and midwives with an explanation of the focus of the inquiry. They were provided with a participant information sheet (see Appendix 1) that included:

- Information on how to register a complaint or concern regarding the study or me as the researcher.
- How to access professional counselling for themselves.
- Written informed consent was required from each participant prior to their interviews (see Appendix 2).

In comparison to Duffy et al's (2002) more comprehensive interview checklist, I was reminded that I had omitted a "Do not disturb" sign, as four of the interviews were interrupted by colleagues and staff members, while in another the background noise of a lawnmower throughout the interview was dreadful. These issues may have been avoided had I been more prepared for these ad hoc events.

Recording voices

The interviews were recorded as part of the data collection method. These recordings were a matter of record and a way of ensuring that the interview conversations were recorded accurately (Flick, 2009). This method of recording data enabled me as the researcher to substantiate my findings using verbatim quotes of the MSWs and midwives (Rapley, 2004) and avoided being dependent on the notes and recall of the researcher. However, there were limitations that needed to be considered when recording interviews. I found that these included the self-conscious way in which both me as the researcher and the MSWs and midwives responded to the presence of the recording device, with thoughts of our own voices being recorded and wilfully using correct language and terminology. Nevertheless, I discovered that these concerns faded as the interviews progressed, and conversations became more natural, being interfaced with accents and colloquialisms, generating rich descriptive data. However, Oliver et al. (2005) consider that only a fraction of what is being said is communicated in conversation and the words used, as the greater majority of what is being spoken of is conveyed in silences, pauses and the tones of people's voices. Emotions were also caught on record, for example laughter, anger and doubtfulness. These nuances are held in the record of the recording. Nonetheless, there were other particulars of the conversational interviews that could not be captured in the recordings, such as postures and facial expressions, and these details are reflected in my field notes (Field notes, pp.16-42).

Transcribing words and more

Following data collection, a transcript was made of each tape-recorded interview. The LREC proposed that I used an independent transcription service, as they considered that as an employee and insider I may prejudice any transcripts. Therefore, at the conclusion of each interview, the recordings were passed to an independent transcribing service. However, I did personally transcribe the interviews in the pilot study and measured my own efforts against the professionally transcribed transcripts. Critically I found due to my insider status I was able to understand the jargon used both medically and locally, but could also interpret any colloquialisms and decipher the MSW and midwives' accents. Both transcription types did incorporate "dirty language" so that what the MSWs and midwives said remained true to their words, for example 'We'd have…' would not change to 'We would have…', whilst the professional service also indicated long pauses in the conversation or laughing. I found that the professional transcription service misinterpreted some wording and had difficulty interpreting clinical terminology. One particular recording was very difficult to transcribe, as the participant's voice was almost inaudible, and had it not been for my knowledge of her voice and use of local colloquialisms there would have been large parts of unidentified voice and chasms of missing data. Therefore, I had to take time to check for accuracy against the recorded interviews, correcting errors before analysis commenced. The personal transcription I undertook was slow and arduous, and unlike the predictions of the LREC the wording was more correct. The exercise also taught me about my interviewing style, as indicated by Kvale (2007). Furthermore, it assisted in recalling particular conversations in the interviews, although the use of the voice-centred relational method provided a similar experience.

Using the voice-centred relational method to analyse data

The work of Mauthner and Doucet (1998; 2003) offers a systematic approach to processing and analysing data in a deeply reflexive way by using the voice-centred relational method (VCRM), which is considered consistent with the feminist methodology (Paliadelis & Cruickshank, 2008). This method originates from Gilligan (1982), who contends that women's voices are not heard when traditional research methods are used, as they are often defined by relationships in a male-orientated world. VCRM was developed as a guide to reading transcripts and listening to the different voices of narrative accounts (Brown et al., 1991). It provides a means of recognising not only who is speaking but who is listening (Brown & Gilligan, 1992; Taylor et al., 1995), and commands the reflexivity of the researcher. Mauthner and Doucet (1998; 2003), having identified the lack of guidance concerning analysing and interpreting qualitatively, adapted and developed this method further and provided more explicit guidelines for its use in sociological research. However, they maintain that this is an emergent approach that can be adapted for use in research.

Mauthner and Doucet's (2008) adaptation of VCRM, or the "Listening Guide," involved four or five readings of the interview data, listening and observing for a specific focus in each reading. Each

transcript was read whilst I simultaneously listened to the interviews audio recording. I repeated this systematic pattern of readings to process each of the interview transcripts.

First reading

The first reading had two foci: the first was reading for the overall story as told by the MSWs and midwives, the main theme, any sub-plot, characters, recurring images, words, metaphors and contradictions, while the second reading was in relation to the reader/listener and recognising their own social, emotional and intellectual responses to the story and its narrator. In practice this resulted in two readings – in the initial reading I reflected on the story in its entirety and documented my reflections, and in the subsequent reading I considered what emotions had been triggered and noted my thoughts and reactions in the margins of the transcripts.

This first reading of the interview transcripts provided not only a better awareness of how MSWs had integrated into the community but also a greater understanding of the relationships that developed with the midwives. As a community-based midwife working in the same Trust, I found that I had had no idea of the interactions taking place between MSWs and midwives before I started this study. This method enabled me to explore some of the intense emotions I experienced whilst undertaking the analysis.

Second reading

The second reading followed how the MSWs and midwives represented themselves in the narrative, and it focused not only on their use of personal nouns 'I', 'we', 'they' and 'you', but also where they located themselves in their own narrative. The use of these words created an image of where they placed themselves, with the nouns 'they' and 'them' representing their oppressors (the employing organisation, midwifery managers and some midwives were placed in this category by the MSWs), whilst 'I' and 'we' represented the oppressed workers as individuals and as a collective group, respectively. This process enabled these multilayered voices, views and perspectives to be deconstructed and understood by me as the reader/listener.

This reading also enabled me as the reader/listener to see where the MSWs and midwives placed me at certain points throughout the interview (as a midwife/researcher, an insider/outsider) and indicated the changing nature of the reciprocity extended by the MSWs and midwives, as often they referred to me as a midwife and my insider status as 'you' and 'you know' and part of the employing organisation. Occasionally, they referred to me by name, indicating the increasing degree of reciprocity being lent to me as a midwife and researcher.

Third reading

The third reading focused on relationships and the resulting consequences, and as the reader/listener I centred my attention on where the MSWs and midwives placed themselves in their working relationships and their interactions with others at work. This was particularly relevant, as this study aimed at exploring the relationships between MSWs and midwives, although this reading accounted for other relationships too, such as those with students, midwife-to-midwife and MSW-to-MSW interactions. In this reading I looked closely at the MSW and midwives' relationships and the way in which they spoke about their interactions on a day-to-day basis.

It became noticeable that the MSWs had all encountered a number of uncertain and negative experiences connected to their role in the community, whilst two of the five MSWs had had some really distressing experiences. These were the two most challenging interviews, as both MSWs had experienced intimidation by midwives and the service. The first MSW only recounted her full story at the close of the interview, and on the advice of family members she had eventually sought support from other midwives in the team. The other MSW remained unsupported by work and colleagues at the time of the interview and spoke throughout the interview in a muted voice that proved difficult to transcribe. I recognised my own outrage and disappointment with the midwives and maternity service with whom and within which I had worked, and that the service had appeared to have considered neither the needs of the MSWs when integrating the new role into an already existing service, nor how it would impact so severely on relationships. These negative experiences also highlighted that support for the MSWs could not be found within the workplace, and so to protect their vulnerability they sought the support of family members. The MSWs who experienced lesser offences appeared to find support from each other by sharing and talking about their experiences. However, I also listened to the positive experiences of the remaining MSWs and identified supportive working relationships with the midwives with whom they worked, and indeed were optimistic about the future of their working lives.

Fourth reading

The fourth reading considered how the MSWs and midwives placed themselves and their relationships against the cultural contexts and social structures within which they worked. This included working within an identified team of midwives, within the maternity service, the community and the hospital Trust. Some MSW and midwives' relationships spilled over into personal and wider friendship networks that provided further support for their professional working relationships.

The advantages of using this method included that it allowed for relational ontology to be translated into a methodology, and it was also a tangible method for facilitating the data analysis of narrative accounts (Mauthner & Doucet, 1998). Moreover, it was systematic in its approach. The stripping off of layers enabled the narrators' (MSWs and midwives) relationships with other people 'in relation to the

broader social, structural and cultural contexts within which they live' (Mauthner & Doucet, 1998, p.126) to be explored, particularly as the focus of this study revolved around the exploration of relationships between MSWs and midwives. Additionally, it provided the opportunity to be reflexive and allowed me to witness as the reader/listener my shifting standpoint along a continuum running from midwife to researcher and back again. Furthermore, I also found that at times it enabled different interpretations of the same material, whilst at other times any intonations or pauses in the conversation made for more accurate interpretation. Overriding factors for use in this study were that this method focused on the voices of the MSWs and midwives and assisted in keeping 'the respondents' voices and perspectives alive' (Mauthner & Doucet, 1998, p.119). This phenomenon continued not only during the analysis but throughout the whole study and beyond.

Following these four/five readings I set about coding the data. Initially I began with the three organising headings that formed part of the aims of the study, namely "roles," "relationships" and "boundaries." This was carried out after receiving and correcting the transcript of each interview. In this way I had a heightened awareness of any "new" or "original" ideas that the MSWs or midwives revealed and was mindful in subsequent interviews to listen for similar or divergent viewpoints. In addition I relied on the recordings and my field note documentation to record any unique opinions of the participants and myself. The three organising headings were broken down further into the organising themes outlined at the beginning of Chapter Four. Included in Appendix 9 is a working example of Helen's (MSW) transcript outlining the different readings, which illustrates how some of the basic themes emerged from the data to form part of the organising themes and overall global theme.

Ethical considerations/issues

This study is littered throughout with ethical issues. Traditionally, ethical concerns revolved around informed consent, confidentiality and protection from harm (Denzin & Lincoln, 1998). More recently they have been grouped into procedural, situational and relational ethics. Procedural ethics are mandated by governing bodies such as the LREC and Trusts, safeguarding against harm and deception, negotiating voluntary informed consent and ensuring the privacy and confidentiality of the participants. Prior to the commencement of this study, formal approval was sought from the LREC, whose purpose was to ensure that the research project was ethically sound and safeguarded the MSWs and midwives. Certainly, research governance is paramount in assessing ethical rigour in health science research; however, as a novice researcher, I found the process onerous and the committee appeared to be predisposed towards quantitative research, and were therefore critical of the numbers involved, the initial interview schedules (version 1), and my insider status as a midwife. Later I recognised that my research proposal clashed with their ideas of what constituted a qualitative study, as discerned by Lincoln (1995) and Parker (2005). Aside from providing ethical approval, the LREC did not provide a monitoring system as noted by Long & Johnson (2006), subsequently as the researcher I assumed ethical responsibility and the study became dependent on my integrity.

Situational ethics are concerned with decisions the researcher is required to make in the field in response to an emerging "dilemma" or "situation." As the researcher I was ethically bound to ensuring that the study would serve scientific and human interests (Kvale, 2007). However, therein lay a dilemma, as these positions, when juxtaposed, conflicted with one another. As the researcher I was forced to measure the human rights of the MSWs and midwives against producing a coherent research study that had the potential to improve their working relationships, but not without revealing their difficulties, dilemmas or distress. I developed an understanding that interview research is steeped in moral and ethical issues. Ethical dilemmas arose due the complexities involved and around the MSW and midwives' disclosures, whereby their personal and private lives were to be displayed publicly – they may disclose information they might later regret, but alternatively they may disclose information about themselves that they do not recognise or know exists. As the researcher I found myself accountable for 'researching private lives and placing accounts in the public arena' (Mauthner et al., 2002, p1), and I was thereby tasked with the decision as to whether or how I should reproduce this knowledge. I struggled with some of the experiences I uncovered, grappled with my own ethical duty and resolved that the way forward was to reward the courage of the MSWs and midwives who agreed to partake in the research, by completing this study.

Relational ethics refer to researchers, their actions and their words and how they are required to observe, as suggested by Ellis (2007), the values of dignity, mutual respect and connectedness between the researcher and the participant. This ethical issue was truly challenging, as on occasion the content of the interviews triggered emotions of distress not only in the MSWs and midwives, but also in me. In these instances I checked that the participants wanted to continue the interview, and when the interview ended I discussed with them how to manage their situation and made certain that they knew where to seek further support and assistance, if required. As part of the LREC agreement, I had been required to ensure that support be made available to the MSWs and midwives, and I made certain I carried the telephone numbers of those available to offer appropriate support, which included independent counsellors, managers and my research supervisor (see interview checklist – Appendix 7).

Not only was it important, to ensure that due consideration given to the procedural, situational and relational ethics during the study, but also to have a strategy to maintain and respect ethical values when exiting the study at its close. Significantly, as the researcher I needed to retain a heightened awareness of the legacy this study would leave and be sensitive to preserving the study's ethical dimensions when considering how best to present the research in the future.

Informed consent

Informed consent involved informing potential participants of the purpose of the study and providing an outline of the study's design. Attention was drawn to the benefits but also the possible risks and

can be considered to be of greater significance should they choose to be involved in the study (Williamson, 2007; Wendler & Grady 2008). It was emphasised that their consent was voluntary and could be withdrawn at any stage throughout the study. It was important that their participation in the research was free of threat, coercion or inducement, although I recognised that some MSWs and midwives may have felt inwardly coerced to participate due, in part, to the power asymmetry (Kvale, 2007) between themselves and the researcher and/or their managers, as discussed in the 'gaining access' section. Conversely, it has also been found that not taking part in studies can also be perceived as harmful by some potential participants (Bradbury-Jones & Alcock, 2010).

Initially, the focus of the study was identified and the aims of the study formed. However, the flexibility of qualitative research allows for changes in its focus and aims, as data analysis continues throughout the data collection period. In other words, what the MSWs and midwives initially signed up to had the potential to change as the research progressed. As the researcher, I had the responsibility to ensure that they were made fully aware of this possible changing influence, and of the risks they may be undertaking when they agreed to take part in the research. Notwithstanding these concerns, informed consent was obtained from each participant in the pilot and main studies, before the individual interviews commenced.

Anonymity and confidentiality

Anonymity deals with protecting the identity of the participant and includes removing the names of people and places from transcripts and replacing them with pseudonyms for the purpose of a study. It was clear at the community meeting that the MSWs and midwives were concerned that they should remain anonymous, and I reassured that them that no-one would be able to identify them as they would be given fictitious names. I explained that only me as the researcher and my supervisors could access the data, which would remain strictly confidential. It was also made clear that the recordings would be erased on completion of the study. Descriptions of the midwives and their demographics can be found in Appendix 10, which is accompanied by an illustration (Figure 2) depicting who was working where and with whom at the time of the interviews.

Confidentiality is viewed as a separate issue, raising issues particularly for the MSWs in view of the small sample size and being unable to assure absolute confidentiality. Indeed, the content, particularly specific quotations could potentially identify the MSWs and midwives, as the personal accounts of their relationships were to be placed in the public domain (Mauthner et al., 2002) and made freely available. Furthermore, intimate details around the MSW and midwives' working lives may be disclosed, as information useful for the study could potentially uncover their identity. In writing up the research, diligence was required in maintaining and respecting the MSW and midwives' confidentiality, and I recognised that I struggled to balance my own ethical and moral philosophies, evidenced by my hesitancy in writing up the study and the overall length of time taken to complete.

Insider/outsider issues

I was keenly aware that in the interest of producing a credible and resonant study my insider-outsider status could not be ignored and my role as a midwife-researcher in relation to MSWs and midwives and influence on this investigation needed to be explored. The LREC challenged my dual status and appeared uneasy about a midwife studying her colleagues (Field notes, p.8), particularly as I worked in the same area. They advocated a neopositivistic standpoint, and seemingly I had parted from this traditional type of research in opting to 'go native'. There is evidence to say that often it is assumed that the researcher is not known to the participants, but there are many examples of this not being the case (Platt, 1981).

However, there was no denying there were inherent complexities involved in conducting research in my own workplace. One of the limitations of an insider's perspective is a 'blinkered approach' and the oversight of common experiences, so things with which we are familiar are not questioned, as we do not see them as others would do so (Schuetz, 1944). Next is the argument that the insider may lack the sophistication to maintain objectivity when examining their lived world (Stephenson & Greer, 1981). According to McEvoy (2002), the insider may be constrained when it comes to 'asking questions about well-established social mores' (McEvoy, 2002, p.50). Furthermore, McEvoy (2002) suggests that insiders may be reluctant to address difficult or sensitive issues with members of the same group, but likewise participants may be reluctant to reveal difficult or sensitive matters to members of the same group – a phenomenon I correlated to my own insider experience, and as already mentioned, one of the MSWs chose to disclose her most poignant experiences at the end of her interview.

There were also advantages of being an inside researcher that valued my insight and membership of the lived world I was researching. These included having the ability to interpret the MSW and midwives' accounts in terms of the terminology and the language used, and being able to attach meaning to their experiences that enabled me as the insider to "read between the lines", "understand what was not being said" and not taking things at "face value" – facets that are congruent with feminist methodologies. Indeed, Kanuha (2000) considers that 'being an insider researcher enhances the depth and breadth of understanding a population that may not be accessible to a non-native scientist' (Kanuha, 2000, p.444). Another benefit of being an inside researcher was ease of access to the potential participants, particularly as the head of midwifery actively supported the study I planned to undertake. No-one from the group of potential participants refused to be part of the study, and no-one who partook in the interviews chose to withdraw their consent. A possible meaning that I derived from these actions/inactions was that I had been accepted to undertake an enquiry around their practices, as I was "one of their own."

I found myself shifting location along the insider-outsider continuum with each interview I undertook, moving from researcher to midwife to woman and back again. Bolak (1996) explains that at times we

will by our virtues be defined as insiders, and when we find ourselves as outsiders this will have been defined by our different virtues, for example gender, age, ethnic background and profession.

Reflexivity

The idea of objectivity in any inquiry is that the researcher remains neutral to the phenomena being studied. However, social research studies involving humans 'makes achieving objectivity even more difficult' (Holloway & Wheeler, 1996, p.189). This qualitative study sought to understand human thoughts, feelings and behaviours, as it was reliant on interviewing and considered subjective (Kvale, 2007). As the researcher I became immersed within the study and formed relationships with the MSWs and midwives, which made neutrality and objectivity difficult to achieve and, which effectively made subjectivity nigh on impossible to eliminate.

Reflexivity has become widely accepted as a central component of qualitative research (Harding, 1987; Haraway, 1997; Carolan, 2003; Kingdon, 2005) and is seen as a process associated with researchers' self-awareness (Kingdon, 2005), a means of self-visibility and a way of dealing with the researcher's epistemological views, by taking account of the different identities the researcher assumes throughout the inquiry. The use of reflexivity allows for the identification of potential researcher bias, which includes the researcher's inseparable assumptions and personal values that they bring to the study (Marshall & Rossman, 2010). The term 'bias' is misleading though, as it indicates negativity, whereas Oleson (1994) considers that researchers' biases can complement the study, providing they remain reflexive.

Furthermore, I considered reflexivity as an essential component of feminist research. I aimed to create a reciprocal relationship with the female participants involved in the study, and needed to be aware of my own beliefs and values and their influence on the research. This self-scrutiny of me as the researcher in relation to the research process gave me a sense of self in the field by creating a greater awareness of my insider/outsider, midwife/researcher positions. Later, I recognised that I had used it as a 'methodological self-consciousness' (Finlay & Gough, 2003) tool which helped identify where I was situated on the insider/outsider, midwife/researcher continuum. My field notes (Field notes, pp.16-42) indicated where I located myself before and after each interview, whereas the voice-centred relational method enabled me to view how my position shifted throughout individual interviews.

For the reader, the use of reflexivity provides them with the 'story behind the story', identifying not only the impact of the researcher on the inquiry but also how the inquiry has impacted on the researcher.

Rigour of the study

Throughout this study I was concerned about what arguments and criteria to use that would validate my research and make it plausible for its audience. I replayed in my mind the words of the LREC and their concerns regarding the small number of participants included in the study, as well as the bias created by my own insider/outsider status, although I now realise that more critical than the numbers involved in feminist research is the richness, depth and resonance of the data. Nevertheless, I remained anxious about how to demonstrate the value and integrity of the study – and me as the researcher.

Qualitative researchers have produced clear arguments against using traditional positive concepts of validity and reliability to evaluate and justify qualitative studies (Altheide & Johnson, 1994; Leninger 1994; Finlay, 2006). Meanwhile, Morse et al. (2002) advise caution in moving away from such concepts, as there is a danger of ignoring rigour, which may result in qualitative research being undermined as a scientific process that has the potential to make valued contributions to the advancement of knowledge (Tobin & Begley, 2004). Therefore, qualitative researchers have appropriated more relevant concepts to assess the goodness and quality of their studies, which replace validity and reliability. Whilst seeking out a suitable framework to use in evaluating the quality of this study I found the literature littered with a multitude of concepts and, much like Morse (2002), confused by the interchanging terminology. Eventually I found a unique model that I considered best suited this study, namely Tracey's (2010) 'Big Tent' model. The model appropriates concepts from other prominent qualitative researchers and incorporates a set of eight key markers by which to recognise and assess best practices around qualitative research. Tracy (2010) summarises these eight 'universal hallmarks' (Tracey, 2010, p.837) as: worthy topic, rich rigour, sincerity, credibility, resonance, significant contribution, ethical and meaningful coherence.

Worthy topic

This study was born out of a personal encounter, as at the beginning of the study I was working as a community midwife where MSWs were employed in a community midwifery service. It could be construed as a worthy topic, as it emerged in response to the then current political climate, which was demanding NHS changes. The study was anticipated to raise awareness, supporting Lincoln and Guba's (1985) 'educative authenticity' of phenomena where there is relatively little known, and challenges assumptions that have been taken for granted whilst revealing findings that previously have been hidden.

Rich rigour

The issue of rigour in qualitative research has recently become a topical debate (Rolfe, 2006; Polit & Beck, 2008) and is often judged by the care and practice taken in data collection and analysis

processes. Aroni et al. (1999) considered that rigour is the means by which the researcher demonstrates integrity and competence and legitimises the research process. The idea of richness is imbued through theoretical constructs, data sources, contexts and samples and by choosing an appropriate tool to make sense of the phenomena studied, and it reflects the complexity and multi-faceted nature of the phenomena (Weick, 2007). It was with careful consideration that I chose the approaches used, together with data sampling, data collection and data analysis processes, as discussed earlier in this chapter.

Sincerity

Tracy (2010) relates sincerity to genuineness and authenticity, which the researcher achieves through reflexivity, vulnerability, transparency and data auditing. Throughout I have drawn attention to my biases and their influence on the study and highlighted my own vulnerabilities when focusing on personal subjective experiences, in order 'to illuminate the readers' understanding of the cultural event, place or practice' (Krizek, 2003, p.149). An audit trail of the events that occurred throughout the process is provided in the indices, as well as the participants' accounts via verbatim quotes. As suggested by Richardson (2000), I endeavoured to be frank and truthful, and questioned my own opinions whilst noting the reactions of others – these are included in my field notes. These self-reflexive practices, which were threaded throughout each stage of the research process, and transparency are considered 'two valuable means by which to achieve sincerity in qualitative research' (Tracy, 2010).

Credibility

Credibility refers to the trustworthiness and plausibility of the research findings. It is concerned with whether the results, in this case my interpretations of the MSW and midwives' accounts, are a true representation of their perspectives. Lincoln and Guba (1985) consider that credibility is built upon thorough and prolonged engagement in the field. The fieldwork in this study was carried out over an eighteen-month period, and throughout I immersed myself in the data, with data collection and data analysis starting simultaneously, although the data analysis extended beyond this period and throughout the remaining study time. The use of thick description is another means of attaining credibility (Bochner, 2000; Finlay 2006). I endeavoured to supply details to "set the scene" and provide concrete details (Bochner, 2000) of the experiences of the MSWs and midwives, to enable readers to draw their own conclusions. As discussed, it was the "concrete detail" that created difficulties for me as the researcher, as I struggled to balance my ethical duties as a researcher and a midwife, as discussed earlier in this chapter.

Lincoln and Guba (1985) recommend leaving an audit trail that can be followed by others, whilst Glaser and Strauss (1967) urge the researcher 'to memo' their thoughts and ideas throughout the data collection process. In constructing this inquiry I inserted practical measures that would assist its

credibility, and endeavoured to maintain a journal and made contemporaneous field notes throughout the experience.

Resonance

The term "resonance" refers to the researcher's ability to engage meaningfully the reader's interest and draw them in accordingly. Sufficiently powerful findings have the potential to resonate with the reader's own experience, or else promote empathy and identify with those who have no experience (Finlay, 2006; Tracy, 2010). I sought to achieve resonance through clear and evocative writing, as throughout the study I used my own emotional experiences as a way of describing, examining and theorising, as called for by Ellis (1991), and identified with the words of Behar, who, speaking on the subject of anthropology, said 'anything that doesn't break your heart just isn't worth doing anymore' (Behar, 1996, cited in Bochner, 2001, p.143)

Significant contribution

At the beginning of this study I emphasised that there was a limited amount of literature available regarding the MSW role, but since then there has emerged a plethora of material. Nevertheless, the studies that have appeared seem to have focused on organisational themes, so there still remains relatively little known about the personal experiences of integrating this new role into community midwifery services, and no known in-depth studies researching relationships in this respect. Theoretically, this research strived to generate knowledge and contribute to understanding the impact produced by this new practice. Heuristically, it anticipated that this is an area of practice that requires further exploration.

Ethical

Ethics pervaded all aspects of this study, with procedural, situational, relational and exiting ethics being discussed in detail earlier in this chapter. Attention to ethical details is considered by Tracey (2010) as a sign of quality in qualitative research, and a reason for inclusion as a universal hallmark.

Meaningful coherence

Tracy's (2010) final hallmark is the measure of clarity (Finlay, 2006), which asks whether or not the study has achieved what it set out to achieve, questioning the extent to which it is systematic in its approach. For instance, does the study work through using methods and practices that suit its adopted approaches, and is there evidence that the researcher has linked 'research design, data collection and analysis with their framework and situational goals' (Tracy, 2010, p.848) in a way that makes sense? No matter how rigour is termed or explained, it appears that what is important is that

the process and findings of the research need to be able to stand up to scrutiny, so they can be used readily to offer new perspectives and understanding of the studied phenomena.

Conclusion to Chapter Three

This chapter examined issues arising from the aims set out in the Chapter One (see p. 15). I have endeavoured to substantiate the reasons for this research being framed within a feminist perspective. I admit to feeling vulnerable when attempting to place where I situated my own thoughts and feelings in relation to the study. However, I am able to appreciate how my own position interrelates with where the study is placed, i.e. within the feminist theories outlined. Undertaking a qualitative approach enabled the use of a feminist perspective and assisted in exploring the working relationships between MSWs and midwives in a community setting. Furthermore, the use of semi-structured interviews generated rich descriptions of the relationships between the MSWs and midwives and taught me to recognise and value the notion of reciprocity between the researcher and participant. The voice-centred relational method employed to analyse the data proved to be time-consuming, but it's worth was to be found in the relationship I built up with the data, and in being able to retain and recall the words of the MSWs and midwives that provided an understanding of their experiences. Ethical issues are inherent in qualitative research, and I feel I grappled with many issues that I never anticipated coming across at the start of this research. This chapter considers and explains how I addressed these matters. Finally, I considered the rigour of the study, having rejected other classic concepts of rigour, eventually finding a model that I believed suited the study, as it embodied the research processes that were included in its design.

In the next chapter I present the findings of the study, using the data captured in the interviews. The analysed data is organised in a manner that enables the reader to understand the lived experiences of the MSWs and midwives and their relationships as maternity services began to integrate the new role of the MSW into an established community setting.

CHAPTER FOUR

<u>Findings of the Study</u>

This chapter analyses data gathered from individual interviews with MSWs and midwives, in order to gain an insight into the role of the MSW. This was achieved by researching their perceptions of the new MSW role. I examined how the two types of practitioner defined the boundaries between their roles, and then I explored the construction of their working relationships whilst integrating the new role into existing community midwifery practice.

Data collection started in April 2007 and continued for a further eighteen months. At this time, MSWs were just beginning to be employed in maternity services across the UK. Conversely, in the town where this study took place, MSWs had been working in community midwifery practice since 2004. The data were analysed using Mauthner and Doucet's (1998) voice-centred relational method (VCRM). Initial data analysis began on the receipt of each interview transcript, which not only facilitated the sampling techniques but also assisted in the observation of any similar or divergent views in the interviews that followed. The final data analysis was completed at a much later date, notably when MSWs had gained a much stronger foothold within maternity services and had acquired increased recognition as their numbers had multiplied. Therefore, the reader is reminded that these recorded accounts are the views of the participating MSWs and midwives based in a specific location and at a particular point in time.

As noted at the end of Chapter Three, this chapter has been organised by the themes that emerged from the analysis of the data. The basic and organising themes revolve around the global theme, whilst the global theme threads through each of the organising and basic themes. I found the global theme hardest to identify, and it remained elusive for some time. However, after I identified that the issue of "confidence" was indeed the study's global theme, the study appeared more coherent. The organising themes arose out of the original aims of the study, and the introductory interview question employed to ease the MSWs and midwives into the interviews and encouraged them to participate more fully in the study. The organising themes supporting the global theme were identified as "Role," "Knowledge," "Boundaries" and "Relationships." The accounts of the practitioners were reviewed further and grouped into meaningful or "basic themes." The words, quotes and meanings of what the participants said, and my interpretation of their voices, were grouped under these "basic" themes, which I interpreted were the most significant issues for the MSWs and the midwives at the time. An illustration outlining the themes is provided in Figure 1 (refer to p.67).
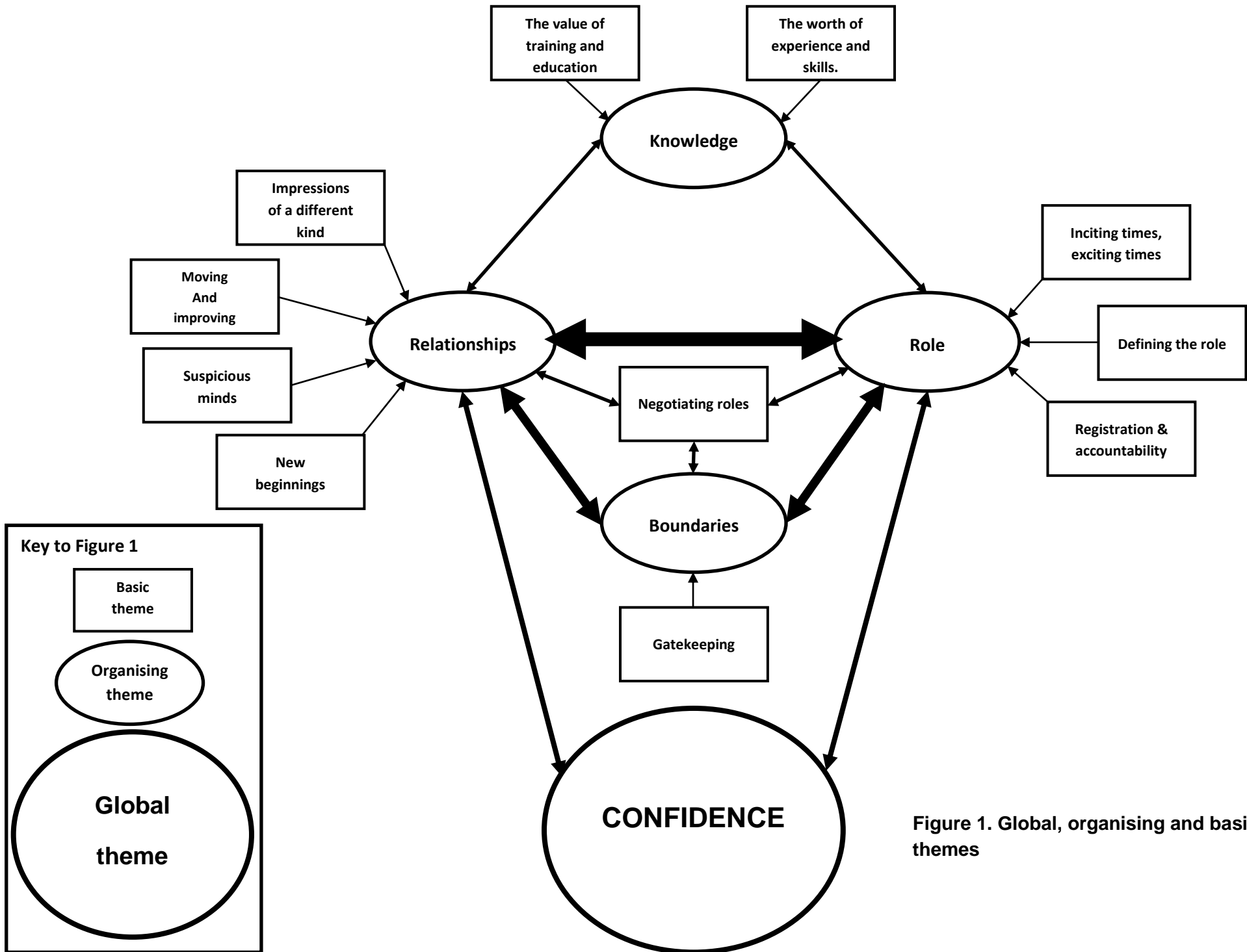
Figure 1. Global, organising and basic themes

The accounts of the MSWs and midwives captured not only the highlights but also the difficulties they encountered whilst attempting to adjust their working lives to integrate the role of the MSW into an established midwifery service. The voices of the MSWs and midwives provided views from both sides of the fence. Notably, this group of community staff not only worked together professionally but also tended to gather and socialise whilst off duty; I was aware that some of them chose to socialise regularly outside working hours, whilst some chose to socialise occasionally at celebratory events occurring throughout the year. This information was acquired as a result of my insider status but was also evidenced in the interviews and documentation of my field notes.

Role of the Midwifery Support Worker

This organising theme was concerned with how the MSW role was perceived by the MSWs and midwives when it was first introduced into community midwifery practice. The two opposing views of these two sets of practitioners were seen as significant in providing the setting of the scene for the study. Defining the role within a setting where midwives were already practicing challenged these practitioners to think and work differently in accommodating this new role. The midwives measured this new role against pre-existing defined roles with recognised status, and raised questions around theirs and the MSWs' accountability and practice. These were the most noteworthy issues for the practitioners and were seen to link to this organising theme. Therefore, data revealing these issues were grouped into basic themes (see Figure 1, p.67) entitled "Inciting times, exciting times," "Defining the role" and "Registration and accountability."

> ### *Inciting times, exciting times*

A key denominator of the MSWs was that they had all been employed previously as healthcare assistants (HCAs) on maternity wards. Initially, only one post was advertised for an MSW to start work in community services. At the time it was considered a pilot scheme and its success (or not) dictated whether the scheme would (or not) be rolled out across the midwifery service in the town. The post apparently created fierce competition amongst the HCAs on the maternity wards in the hospital, as explained by Helen:

> *Well, when the job obviously was first-uh... They said they were gonna have these jobs, I did apply for a job. Obviously there was so many [applicants], but they only wanted a trial one. Didn't get that one. So I went on subsequent interviews and then I finally got a job in community.*
> *(Helen MSW)*

Helen indicated that after trialling the initial MSW post, other MSW posts followed at six-monthly intervals. This meant that by the time this study commenced, the number of MSWs employed within community midwifery practice totalled four in this town, with a fifth MSW working in the Trust's hospital community midwifery service, in the adjoining county (see Figure 2, appendix 11). It was an exciting

time for HCAs, as the role provided challenges and opportunities for new adventures. An attractive aspect of the new role proved to be the opportunity to work office hours with minimal weekend work, and this was cited by some of the MSWs as one of the main reasons for applying for the MSW post. Carmel outlined the merits of this new pattern of working and, in doing so, disclosed the detrimental effect that working shifts in the hospital for a protracted number of years had had on her mental wellbeing:

> *I worked on the wards, on wards for twenty-two years as a healthcare... But the post... This came up first post came up… now which is very good and I really enjoy it. It's a lot better than shift work. It was getting me down a little bit. It is Monday to Friday… Part-time… I do... I do odd parent-craft on a Saturday, I do on a Saturday on Sunday I have parent-craft, so I do that as well.*
> *(Carmel MSW)*

This reflection by Carmel on her mental health offered a glimpse into her inner feelings. Later, we hear Carmel tell of how her experiences working as an MSW affected her overall wellbeing, which may explain why she referred to her mental state so early on in the interview. Likewise, Gillian had also worked on the wards for a number of years and sought to escape the confines and limitations of working as a HCA. Moreover, she admitted to being attracted to the lure of the chance to rid herself of the shift work demanded by working within a hospital:

> *I'd worked on the wards for a long time really. Uh, and to be honest a lot of it was not having to work shifts anymore. Uh, just... I thought the job would be better compared to working on the wards. Uh, and it's just more experience.*
> *(Gillian MSW)*

Gillian's words also suggested that this new role provided new opportunities to progress further and develop new skills. In comparison to the MSWs, the introduction of this new role into local maternity services incited various thoughts and feelings in the midwives, who were expected to accommodate the MSW role into their everyday working practice. There were divided opinions amongst the participating midwives regarding the creation of the MSW role. Heidi, a midwife, referred to this division in the workforce and offered her opinion on where she saw the divide. After specifying how many of the community midwives she believed opposed this change in working practice, she disclosed her own thoughts on the matter:

> *I... I would say it was probably divided fifty per cent between those of us that were thrilled and could see the potential, and I didn't... didn't feel threatened in any way…*
> *(Heidi MW)*

Heidi's words revealed more than what she actually said. Firstly, having spoken about how half of the workforce applauded the new role, it could be deduced that the other half of the workforce was in opposition. Secondly, instead of taking Heidi's statement that she 'didn't feel threatened' at face value, an alternative interpretation of her words may in actual fact be her admitting to feeling threatened. This aligns with Oliver et al.'s (2005) summation that only a fraction of what is being said

is communicated in the words being used. Using the VCRM usually helped to determine how to interpret what was being said by the practitioners, by reading and listening to their words and determining how they were heard. This was an example of where I found it particularly difficult to interpret the words of the practitioner.

Frankie and Bridget had worked as community midwives for numerous years only ever working alongside other midwives, but it was apparent they shared similar ideologies. For Bridget, the plan to insert a non-midwife into the midwifery team seemed such an alien idea and she had difficulty envisaging how such a scheme could work in day-to-day work undertaken by midwives:

> *Well, if I'm honest, when she [the MSW] first came here [place name]… I wondered what she would, you know, because I'd never worked with a healthcare assistant before in community. You know, you think "I don't think there's any work for her, it's all midwives' work"…*
> *(Bridget MW)*

Bridget provided an opinion of her own working practice, whereas Frankie's thoughts were more generic. Frankie considered how this new working practice affected the working practice of all the midwives, in hospital and community, having worked in both areas and experienced various changes in midwifery practice over the years:

> *... I mean, and I've been a midwife and qualified in eighty-three, so for... But all in these last sort of few years you can see that the role is changing. I mean, how many midwives in the past would even consider having a healthcare working with them?*
> *(Frankie MW)*

Frankie expressed her own perceptions around her thoughts on what other midwives were thinking about this matter. Listening back to the way in which she spoke, I determined that Frankie alluded to her own notions of working alongside a non-professional as ludicrous, and she presumed this was true for other midwives. This way of thinking was inferred not only through her actual words but also the clear intonation of her voice as heard on the interview recording. It can be interpreted from these midwives' accounts that their experiences influenced their perceptions, thus highlighting their lack of confidence and uncertainty around the MSW role.

Defining the role

Originally, the pilot scheme established the responsibilities of the MSW and assisted in defining its role description. On securing a post, each MSW was supplied with a copy of the role description along with their contract of employment. The midwives expressed their dismay that they had neither received nor were able to access a copy of the MSW role description, and they made very clear their concerns regarding this oversight or omission, and it was apparent that this caused a great deal of angst amongst them. For Frankie, the actual existence of a role description was wholly uncertain, and was seen deliberating the matter:

But there's no sort of, like... there is no job description... there's no... I mean, I know they have a job description, but I mean... And I'm sure they do for the community…
(Frankie MW)

Noticeably, Frankie in her intonation was disconcerted by not being able to access the MSW role description. The contention over this lack of access appeared to be around its usefulness as a tool to define clearly the role of the MSW and assist in the day-day working of the midwives with the MSWs. Bridget explained how, as a midwife, she would have found it useful to have had a copy of the all-elusive role description:

I think that it would have been useful to me, certainly in the early days, to have known what their role was. That they can do this, this and this and this, as that would have made it easier for me to know what I could delegate. I found it was a bit difficult in the beginning not quite knowing what her role was and what work I could give her…
(Bridget MW)

Bridget was not alone in this matter, as many of the midwives indicated that they had also never seen a copy of the MSW role description. In her interview, Toni again noted the lack of the all-important MSW role description, but moreover she highlighted that she had never received any formal communication or taken part in any debate, other than the informal discussions that had occurred between her own midwifery team members. However, she surmised that there must have been some discussion at some point, probably during the community midwives' meetings that were held on a monthly basis that she had somehow missed:

... I mean, there perhaps was some verbal discussion about... I'm sure there probably was at community meetings, there must have been some... some verbal discussion about what support workers... when they were first introduced to community, what sort of roles they would have, but certainly we didn't get anything on paper…
(Toni MW)

From these comments it appeared that the midwives felt frustrated by the lack of any communication, either written or verbal, regarding the MSW role description. They believed that clarification of the role would assist in knowing what tasks they could entrust to the MSWs, and the midwives concluded that this could have alleviated some of the stresses associated with delegating work. Moreover, the matter was seen as an area of tension that added further pressure on the working relationships between the MSWs and midwives.

The MSWs also spoke of the midwives lacking understanding around their role. After completing their apprenticeship in the training team and starting work in their new teams, it became apparent to the MSWs that the midwives had no idea of the MSWs' skills, and they remained uncertain about which jobs or tasks they could undertake. Helen recalled the reception she received from her new team, and she imagined some of the questions she believed the midwives must have posed before she began working alongside them:

> *Well, I would have said the... the... the ones that were out here when I come out, "Well what can she do, what...?" You know, and they didn't know...*
> *(Helen MSW)*

Helen's words indicated that the MSWs were aware of the midwives' reservations about the role, which became more evident in how the midwives addressed delegating work to the MSWs. The pilot MSW Kate, who had assisted in establishing the initial role and helped train and support the new MSW recruits, had a considerable amount of experience working in the community. As a result, she was more self-assured in her role and about the skills she had acquired. Therefore, when placed in the Trust's community midwifery practice in the adjoining county, attached to a different set of midwives, she felt confident in taking a more proactive stance:

> *… the midwives and myself sorted what would be appropriate in the community for me to do, so to speak, and then I came over here with the skills I did in [last place of work]… When I came to work for them they welcomed me, they welcomed my skills and I feel it was a good move for me coming over here [new place of work] and I told them what I did… I did actually come over and I didn't say to them what would you like me to do – I told them what I did.*
> *(Kate MSW)*

Kate's greater experience was accompanied by her confidence in understanding her own skills and knowledge, which she felt able to communicate to her new team of midwives. It appeared the MSWs had a better understanding of their own role than the midwives. This was probably due in part to the MSWs carrying out their role on a daily basis, but notably each was able to refer to a copy of their role description. Conversely, the midwives appeared to be wholly uncertain about the role, very likely as a result of the poor communication about the MSW role and the absence of a definitive job description. Yet, in her interview, Helen verbally referenced its actual existence. Furthermore, she had provided her team of midwives with a hard copy:

> *... I think actually we've got it pinned up somewhere still.*
> *(Helen MSW)*

Overall, the MSWs appeared to be clear about their role and the functions of their job, certainly more so than the midwives. The existence of a role description was an obvious area of contention for the midwives, but this was not just about a piece of paper – it was about effective communication between managers, midwives and MSWs. The midwives perceived a lack of formal communication that hindered them in carrying out their work effectively. Arguably, this inaction or oversight had the potential to affect or even harm the development of the relationships between the MSWs and midwives.

Registration and accountability

The issue of MSW registration was raised by the midwives, in particular Frankie and Hannah. Frankie, a midwife, had mostly worked alongside other health professionals and offered her own historical view

of midwifery practice. She recalled that *'in the good old days we used to have enrolled nurses and registered nurses'.* These words offered an insight into how midwives had previously worked alongside non-midwives, although notably these staff groups had held a professional qualification (refer to p.24), which Frankie was keen to point out, stating that *'at least enrolled nurses were on the register'.* Frankie's words indicated not only her mistrust of the MSW role but also questioned its credibility. Clearly, registration was a concern for the midwives, as Hannah, another midwife, also noted that the MSWs had *'not got that qualified nursing registration'.* At the time, the MSWs had National Vocational Qualification (NVQ) certification, but they did not have any registration status. Unlike midwives and nurses, MSWs were not required by law to register with any national body of governance and there was no central enrolment register. However, there have been several calls recently to regulate MSWs and their practices (Hey, 2008; NMC, 2010; RCM, 2010; NLIAH 2010), with NHS Employers (2011) proposing a voluntary regulation scheme, which is currently undergoing a UK-wide consultation. However, to date, there remains no agreed regulation.

Accountability appeared to be another factor that was critical in a midwife's decision to delegate work to an MSW. MSWs and midwives are accountable to their employers and follow a contract of duty. Midwives are further accountable to their regulatory body, the Nursing and Midwifery Council (NMC), and have to maintain standards of client care (Cox, 2010). However, all practitioners have a duty of care and have a legal liability with regard to the client (RCN, 2008). The midwives made mention of their accountability, and Toni had particular concerns about this aspect when choosing to assign any work:

> *Uh, and you're very aware that you're accountable, that... that I'm the one that... The same with student midwives; you're accountable at the end of the day, and if you've given somebody and delegated part of your role, you have to be certain that that person is competent to fulfil that role.*
> *(Toni MW)*

It is interesting that Toni noted how she delegated work to MSWs was similar to how she managed delegation to students. Furthermore, she provided details of the changes that she had undergone whilst adjusting her working practices to accommodate the role of the MSW in her day-to-day work. She recollected her initial thoughts and feelings at the beginning of the process and mentioned how these had altered over time. She also noted how she relied on the steadfastness of the MSW to report back to the midwife:

> *I do remember feeling uncertain about what her role involved and a little bit reluctant to give things to her, because I didn't know what she was capable of dealing with and I didn't want to overload her… Uh, and that they are aware of their limitations so they'll get back to you if there's any problem that you have to deal with. And, like I said, I mean, now I... I feel much more comfortable that I can do that...*
> *(Toni MW)*

Toni raised concerns over the MSWs being aware of their own limitations, and her words indicated how she felt assured and had built confidence in the MSWs' abilities to recognise and report back any issues outside their scope of practice. Clearly, the midwives were dependent on the MSWs reporting back any issues, thus becoming accountable for actioning such matters that required the attention of a midwife. These issues relate to the midwives gaining confidence in the MSWs' abilities in understanding their scope of practice regarding their boundaries of their role, but they also relate back to the midwives' accountability around their duty to delegate appropriately.

Relationships

This organising theme considered the working relationships between the MSWs and midwives. The basic themes span a spectrum of the relationships that developed between the practitioners. These themes related not only to how their relationships formed and how they progressed, but also noted factors that affected changes in their relationships. These aspects are organised into the basic themes entitled "New beginnings," "Suspicious minds," "Moving and improving" and "Impressions of a different kind".

New beginnings

This was a new beginning for the MSWs and midwives. Whilst defining their new role in the community, MSWs needed to build numerous relationships. These new relationships included individual midwives, midwife teams, organisational and managerial teams, other affiliated professionals (GPs), third party organisations (Children's Centres) and, most importantly, the women and the families to whom they were providing care. The MSWs, some of whom had numerous years of hospital working, had had the opportunity to work with some of the community midwives before they themselves became community workers, as Helen, an MSW, noted:

> *A couple of them knew me, but I hadn't worked with them for fifteen years, so I was fortunate in that aspect that people knew me...*
> *(Helen MSW)*

It seemed Helen appreciated this fact, but more importantly it instilled confidence in knowing some of the midwives she was to be working alongside. In contrast, the midwives had only one extra relationship to foster, although they also had to modify their working practice to accommodate their new teammate and adjust to the team's new dynamic. Bridget, one of the midwives, having *'never worked with midwifery assistants before'*, outlined her own doubts when faced with this new way of working:

> *I was sceptical about whether a healthcare assistant could [hesitation] be of any benefit to us in our team. I think you [hesitation] at first because I didn't know her, you're sort of reluctant. I was reluctant sometimes to give her a certain visit, because I used to think, well, because I think that probably needs a midwife to go in…*

Bridget's hesitation in stating her doubts was possibly the result of trying to find the right words to convey what she felt, but perhaps it also hinted at her under-confidence in the role as she started to work collaboratively with the MSW. As the working relationship developed, Bridget recounted how she became more familiar with the MSW as a person, a phenomenon that assisted in her understanding the MSW's knowledge and competencies:

> *… whereas maybe later on, when I'd got to know her and know her skills and her abilities, I knew that it didn't have to be me that went into that woman…*
> *(Bridget MW)*

Bridget's words implied a gradual shift in her attitude, until eventually she felt confident enough for the MSW to work in an unsupervised capacity. Seemingly, Bridget placed equal importance on getting to know the person as much as understanding their knowledge and skills. Communication between the MSWs and midwives was pivotal in developing their relationships, and it seemed to be valued by both practitioners, while the midwives appeared particularly appeased when the MSWs reported their findings to the midwives after visiting women and their families. Alex explained it was also a way of the MSWs checking that their actions or information and support they had offered was correct, especially in the early days working in the community:

> *If I've got a problem I'll phone and that's what I were doing, so, sometimes people got used to that…where they feel, "Oh well, she's quite good; she does it and we know if she's got a problem then she'll phone us…"*
> *(Alex MSW)*

Moreover, as they began working in the community the MSWs found mobile phones invaluable and used them as a conduit for reporting back to the midwives. They all commented on how many phone calls they made in the beginning, but also how the number of calls reduced as they became more proficient in their work. The mobile phone was an essential tool for reporting and checking back with the midwife. Kate explained how she appreciated the use of a mobile phone, not only as it provided instant access to information from the midwives, but also how it helped define her MSW boundaries:

> *I couldn't do my job without my phone… and believe you me, there were a lot, a lot of phone calls them first few months, phoning back to the midwife, you know, before I actually gained more knowledge and confidence… probably the thing that did drive me mad, like I say, was the phone calls at first when I was establishing what was in my remit and what was theirs… That line is a phone call away, that's all it is – a phone call…*
> *(Kate MSW)*

Initially the midwives reported that they were overwhelmed by the telephone calls from the MSWs as they started their new posts, but as time passed the midwives noticed a decrease in the amount of calls they received. The communication was seen as a means of the midwives building confidence in

the abilities of the MSW; indeed, one midwife, Wendy, associated the reduction in calls to the MSW becoming self-reliant on their own knowledge and skills:

> *You know, and I felt I was always getting like the phone calls from her, but it's not as much now. You know, she's got that experience and that confidence to make a decision.*
> *(Wendy MW)*

Overall, it appeared that all the practitioners appreciated this two-way communication whereby the midwives were informed and kept up-to-date with the care of the women and their families whilst the MSWs had the opportunity to accrue knowledge and skills through this system of communication and feedback. Certainly, regular communication between the MSWs and the midwives assisted in the development and construction of their relationships – the MSWs became more confident in their roles, whilst the midwives gained confidence in the MSWs' skills and knowledge, and felt assured that the MSWs would report back to them appropriately. Furthermore, the practitioners were able to use these opportunities to negotiate their roles.

Suspicious minds

Frankie and Toni revealed their concerns for and their understanding of the reasons why maternity services had chosen to employ this particular type of practitioner, surmising that MSWs were '*cheaper to employ than a midwife'* and '*a cheap form of midwifery', respectively.* The midwives suspected there existed an ulterior motive behind the introduction of the new role, and they feared the erosion or even the eradication of their role entirely. Frankie believed these actions , in her opinion, were '*the thin end of a wedge'.* The MSWs were very conscious of the suspicious thoughts and feelings of the midwives. They were aware that up until that point the midwives had been autonomous practitioners, some for many years. Furthermore, the MSWs recognised the midwives had had the MSW role thrust upon them and were under pressure to accept and work alongside a new practitioner role that could possibly usurp their own role in the future. Gillian believed one of the reasons why some of the midwives were reluctant to use her skills was because they did indeed feel insecure:

> *A bit threatened, I think, or we don't need her. I've done it for so long.*
> *(Gillian MSW)*

Some of the midwives reported what they believed to be a very real threat to their livelihoods. Heidi, for instance, remembered one such conversation with the midwives in her team and recalled that it was, in fact, quite a heated debate:

> *… and uh... and then some... there was other midwives who I... well, who did voice that they felt that it was inappropriate, because where does that leave us, huh? They'll... you know, they'll... they'll be getting rid of midwives and just having support workers.*
> *(Heidi MW)*

Clearly, the midwives felt their roles were being undermined and put under threat. Carmel interpreted the actual behaviour of one of her team members towards herself as highly defensive, and she tried to figure out the reasons behind the midwife's demeanour. Carmel considered herself to be outgoing and popular within this team and the wider community team, but the midwife's conduct left Carmel questioning her own behaviour:

> *I think sometimes... I know I don't want to sound big headed, but I can imagine there might have been a bit of jealously, 'cause I know lots of people and I'm quite a bubbly person and I get on with everybody… She don't have to feel threatened with me; I'm not that sort of person I wouldn't have thought. I'm not, am I?*
> *(Carmel MSW)*

Carmel's words were in total contrast to the person sitting in front of me in the interview. My insider self recognised the old "bubbly" Carmel, but the person who I was interviewing was a very changed person, a shell of her former self, unsure, withdrawn and self-doubting. She had spoken about the midwife feeling threatened, but the midwife's behaviour was in fact threatening to crush Carmel's identity. Carmel recalled that she *'used to get into such a state' and 'I used to go home and cry',* and admitted *'she's changed me, I'm so different… I'm so different a person, I'm not the same person at all'.* This aggressive oppressive behaviour of one midwife had affected Carmel's health to such an extent that she had required support from the hospital's occupational health department, her GP and a specialist. Her plight warranted the attention of her manager, who surreptitiously moved a midwife into the team who Carmel identified as a trouble-shooter, as she *'came out… to sort stuff out, really',* and negotiate the roles between the MSWs and midwives.

Certainly, it seemed that the MSWs were exposed to relationships with midwives who perhaps felt threatened by this new role. Consequently, the MSWs appeared to display heightened sensitivity to the feelings of the midwives, and several of them attempted to contextualise this perceived feeling of ill-will. Some midwives were either not proficient enough or did not care to hide their feelings, whilst others intentionally chose to display their hostility towards the MSW role. Another area of suspicion for the midwives was indeed the erosion of their role, in that the MSWs could possibly become responsible for an area of practice that was once considered to be the realm of the midwife. This was certainly a consideration for Wendy, another of the midwives, who witnessed the MSWs becoming more skilled and proficient in supporting breastfeeding mothers and appeared to fear the erosion of these particular skills in midwives. Furthermore, Wendy was anxious that she was being restricted in maintaining and developing new skills of her own:

> *She's the one going in and seeing and doing and then ringing you saying, "This… this… this and this, what do I do about it?" But yeah, she's gaining a lot of that knowledge, whereas we're not.*
> *(Wendy MW)*

Although Wendy's words appeared harsh, there was also an air of disappointment (detected through using VCRM), indicating her anguish regarding her losing these skills. Another midwife, Frankie, had

suspicions of her own and also mentioned the deskilling of midwives. Moreover, she inferred that the midwife's role was gradually being subsumed by the MSW:

> *I mean, really, and she's [the MSW] committed and she's dedicated and she spends a lot of time with these women, but do you know sometimes, it's... you know, I'd like to spend that time with women as well… But then you're thinking, "Well that's what I should be doing. I'm a midwife, that's what I should be doing. I shouldn't be negating that to somebody else."*
> *(Frankie MW)*

Frankie began by commending the hard work of the MSW, but then she went on to vent her frustration on the restrictions placed on her as a midwife, which included other commitments and their time limitations. Her consternation that MSWs had no such restrictions placed on their role was emphasised not only in the words she used, but also in how tersely she spoke, which was heard much more clearly as a result of using VCRM.

Midwives have been recognised as being part of a profession since the passing of the 1902 Midwife Act and have been able to maintain their professional status (refer to Chapter Two) as a result of using the professionalising strategies (Hughes, 1958; Freidson, 1970; Larson, 1977 Abbott & Wallace, 1990; Dietrich & Roberts, 1997). Frankie reflected on her nursing experience and judged that until that point midwives had indeed been able to maintain their role. She anticipated the development of the MSW role would somehow displace that of the midwife:

> *I mean nursing now, the role of nurses now, to what it was when I was a student nurse is totally different. It... it's not the nursing that I knew. I know it evolves and I know it progresses… but midwives have kept their role, because of the nature of the job, where nurses haven't, but now...*
> *(Frankie MW)*

Clearly, the midwives were suspicious of the role, afraid it may erode their own role and fearing that their positions and standing in the community may be replaced by MSWs. The MSWs were aware of the midwives' concerns and therefore needed to reassure the midwives that this was not actually the case, which they did by using reporting back mechanisms to assuage their fears. However, for those midwives with the greatest suspicions, their fear was seen to manifest in extreme professional closure strategies such as those experienced by Carmel (refer to p.77 & p.90). Other lesser offences the MSWs cited were experiences such as being ignored or disregarded by the midwives. This was demonstrated by some midwives through their actions, or rather inactions, to delegate work to the MSWs. Kate recounted an incident of one particular midwife who was *'very reluctant to use us [the MSWs]'.* In her scenario, Kate had visited a woman and newborn baby on the midwife's caseload to provide breastfeeding support and *'handed her back to her own midwife who came back off her day off'.* Kate recalled:

> *I never saw that woman again; I didn't know whether she ended up bottle feeding or breasting until I had to say to her [the midwife] a few weeks later when I saw her and I said to her how*

did that lady get on? Not only did I feel, I felt quite hurt by that really, because I knew I was making progress with this woman and because of the midwife's attitude of not wanting to use me. I thought, like, how can I put it? I felt useless as if, I felt hurt… I was not acknowledged…
(Kate MSW)

The midwife's attitude appeared to undermine Kate's feelings. In essence, the attitudes of the midwives had a profound effect on the relationships they constructed with the MSWs. It was interesting that the MSWs identified these midwives through the use of words such as 'a certain midwife', or 'a particular midwife', whereas the remaining midwives were acknowledged collectively as 'the midwives' or 'the girls' or individually as 'the midwife'. The midwives' suspicions were discernible from their interactions with the MSWs. The degree of uncertainty about the role was illustrated by the amount of work they were willing to delegate to the MSWs. Indeed, Gillian, an MSW, revealed that some midwives in her team were ambivalent about the MSW role and remained hesitant in using the MSWs' skills in caring for new mothers. This ambivalence, Gillian believed, stemmed from the midwives' anxieties around the MSWs usurping the midwife role. Heidi, a midwife and member of the same team, had previously tried to moderate discussions between team members, but the midwives remained indifferent to the MSW role, as Gillian explained:

Not that they weren't willing to accept me… I wouldn't say not a good relationship, I think it's took a few of the other... you know, like, a few other midwives may be a bit of time to... to accept, I shall say me, as a midwife support worker.
(Gillian MSW)

Therefore, it seemed that a more concerted effort was needed to convince some of the more reluctant midwives of the benefits of having an MSW in the team. Gillian and Heidi's plan is detailed in the next section 'Moving and Improving.' Similarly, the midwives in Carmel's team initially appeared dubious of her MSW role and in fact they measured each midwife's cautiousness by the amount of work they were prepared to delegate:

Actually there's only one or two that'll give me… Well, one in particular that'll give me lots of work, but that is it – the others just keep it to themselves.
(Carmel MSW)

It appeared that these ambivalent relationships were a short-term response to the MSW role while it was being integrated into the community. The length of this term was determined by the midwives and demonstrated that they remained uncertain of the MSWs' role and were hesitant regarding its intentions.

Moving and Improving

Encouragingly, the data showed that the situation of the MSWs did improve over time. Obviously, they were aware of their working environment and noticed changes in the attitudes of the midwives,

particularly in relation to their new practitioner role. Helen, an MSW, reflected on how one midwife acknowledged the changes in their own attitude:

> *I worked for a few months with her and I was very surprised at what she said. She said, "Well, Helen," she said. "I didn't think support workers had a role out here, but you've proved me wrong."*
> *(Helen MSW)*

Helen's words suggested that this transitional change took place over a period of time, as it was some time before she actually received praise from the midwife who had been initially doubtful of the MSW role. Similar to Helen's experience, and as previously intimated by Gillian, another MSW perceived that one of the midwives was reluctant to employ her skills and shared her concerns with Heidi, a midwife. Heidi outlined how she and Gillian hatched a plan to reverse the midwife's reluctance, to encourage a more conducive working relationship and to prove to the reluctant midwife there were advantages of having an MSW in the team:

> *One of the midwives in, uh, another area [in the same team] couldn't see this... could see what she could do… and I said, "The way to do it is go and help her at her clinic…" And this midwife still couldn't see what... you know… till Gillian went in and did… she thought it were marvellous and can't do without her now. I think that the relationship improved not... not that it was bad… but she just... she just defied Gillian's existence.*
> *(Heidi MW)*

Placing the MSW to work alongside this reluctant midwife not only challenged the midwife's preconceived ideas of the MSW role, but it also enabled the midwife to observe and experience how MSWs actually worked in practice, as up until then the midwife had only her preconceived ideas to draw upon. As a result, the experience positively influenced the midwife's attitude towards the MSW, and the MSW-midwife relationship went from one of non-existence to one that was held in high-regard. So it seemed that time, effort, actions and self-belief were required to improve the working relationships between these two sets of practitioners.

Bridget recalled not really being affected by these new changes as the MSWs began working in the community, and she described herself as existing in her *'own little bubble',* being oblivious to these new events, as a result of her team having not been assigned an MSW. Consequently, Carmel, an MSW, was allocated to the team for a brief period before being moved to another area of the town. Bridget outlined how she modified her thinking about the MSW role and the efforts she made to nurture good working relationships between herself and Carmel. In this short period of time of working together, Bridget had moved away from her initial scepticism regarding the role and told of the juncture she had reached and how she saw the MSW role in a much more positive light:

> *… there's no reason why a healthcare assistant; she isn't pinching work off a midwife, she is assisting you, so she's making your life easier really…*
> *(Bridget MW)*

Similarly, another of the midwives, Toni, had come to appreciate the assistance provided by MSWs, and she viewed them '*certainly as a support, as an addition to the service that we provide',* to the midwives and to women and their families. Toni had shifted her opinion away from the suspicious one she had assumed at the beginning of this experience (refer to p.73). The idea of getting to know the MSW as a person and individual seemed just as important as understanding their knowledge and skills, which enabled the MSWs and midwives to build meaningful relationships. Gillian spoke of the midwives in her team getting to know her as an individual in relation to her working abilities. Moreover, Gillian believed the element of trust was instrumental in developing the relationships between her and the midwives:

> *They've got to learn to know me as a person as well, you know, knowing what I can do and how I am with patients and things. I suppose it's having a bit of trust, isn't it, really?*
> *(Gillian MSW)*

Gillian had observed that as their relationships developed, trust between the MSW and midwives increased. As a result, it seemed the midwives lessened their control over MSW practices and, in effect but probably more significantly; the midwives moderated their gatekeeping practices. An example is provided by Heidi, a midwife who worked alongside Gillian, an MSW, on a regular basis. She described their working relationship, and her words appeared to endorse this same theory:

> *I... I think that Gillian trusts us, but we definitely trust her, yeah… I've got a deep trust in her and I've never ever thought, "Oh, Gillian, you know you shouldn't have said that or I think I ought to have gone."*
> *(Heidi MW)*

The notion of Heidi's existence of 'deep trust' indicated that a reciprocal working relationship had developed between these two sets of practitioners. During her interview, Heidi stated their relationship was '*fab'* and announced that '*we're gonna get married',* giving the impression that their professional partnership was, indeed, working very well. Toni, another midwife, noted that trust developed whilst working together as a result of being able to trust the MSW to '*feedback to you [the midwife]'* after visiting women and their families. Throughout her interview, Alex mentioned trust many times and viewed it from the perspective of being able to trust a mentor to maintain confidentiality. It appeared that Wendy related trust to the length of time she had known and worked with the MSWs:

> *Well, it must be 'cause when Kate... I trusted her, you know, totally, because she'd worked a long time with us on the wards as well. You know how she worked; you knew what she was capable of. Totally different when Alex... came out, 'cause I didn't know her.*
> *(Wendy MW)*

It seemed for Wendy that trust was the basis of her working relationships with individual MSWs. This linked with the notion of the MSWs reporting back to the midwives the results of their actions, and related to Heidi's concern about trusting the MSWs to say and do the right thing, so that the midwife was not left thinking that they should have undertaken the visit, task or work themselves. The idea of

the MSWs and midwives trusting each other correlated with the practitioners' increased confidence in the role. This was seen to affect the negotiation of their roles and practice and influenced the midwives in relinquishing more of their control over their professional closure strategies.

Impressions of a different kind

In her observations of the relationships between the MSWs and midwives, Wendy noticed that some, although not all, resembled a parent-child relationship. This phenomenon was observed in the training team, as this was where Wendy worked. Wendy's first example portrayed the midwives as the children in the relationship:

> *… do you know how I used to see the MSWs when they first came out? Particularly Kate... as the mother of the team… You see Carmel... was another similar character to Kate... similar experience… because they were friends as well, that they were both seen as, like, the parents [laughs].*
> *(Wendy MW)*

Kate and Carmel were both older, more experienced MSWs, who had children of a similar age, and whilst Carmel had grandchildren, Kate did not (inside knowledge and field notes). These details may or may not have influenced Wendy's view. However, Wendy also reflected on the interactions between the team members with another MSW, Alex, and it was her opinion that the midwives had collectively built a different type of relationship with this MSW:

> *Whereas with Alex... she seemed like the child. We were having to look after her and help her, and, totally different.*
> *(Wendy MW)*

Alex was the one of the youngest and least experienced MSWs. In her comparison, Wendy appeared to be measuring the difference in their levels of skills and the amount of confidence they demonstrated to the midwives. Indeed, it appeared the midwives had had to invest more time into nurturing Alex' skills and confidence:

> *It did help her to sort of, to give sort of advice to mums, because the one that had had a lot of experience was able to do that just through the experience she'd gained. Whereas the other one that was new to it [the MSW role] tended to rely on us to give her that, you know, to ask us before she could tell the women.*
> *(Wendy MW)*

Interestingly, this impressionistic view of the interactions between the two types of practitioners being evocative of a mother and child relationship was not voiced by any other of the practitioners, although Heidi agreed that the midwives had to 'look after' the MSWs, in reference to reducing their exploitation as handmaidens to midwives. In turn, Kate spoke of the large number of midwives in the team in which she first worked, and it appeared she felt disappointed that she was unable to assist each of her team members:

> *I always felt I was never doing enough for all the midwives… I felt I couldn't spread myself far enough to help everybody…*
> *(Kate MSW)*

It seemed that Kate's words reflected Wendy's impression of attempting to "mother" the team in view of the special relationships that she built up with the midwives. The way in which Kate spoke also revealed that this aspect of underachieving saddened her significantly, which was more noticeable when using the VCRM than reading the transcript on its own. This mother-child relationship also relates to the notion of confidence in being cared for and looked after, which was alluded to by these practitioners.

Boundaries

This organising theme was concerned with issues around defining and maintaining boundaries of both sets of practitioners. The data presented illustrate not only how the MSWs defined their boundaries but also how they recognised the limitations of their own practice. Moreover, they demonstrate how the midwives identified and ensured the maintenance of these boundaries. The data supporting this organising theme were categorised into two distinct or basic themes, entitled "Negotiating roles" and "Gatekeeping."

Negotiating roles

From its inception there existed a role description (Appendix 11) for the post of the MSW. Kate, who initially piloted the job, also assisted in negotiating and establishing the role in collaboration with the community midwives in the pilot/training team. Kate commented on how they worked together to integrate this new service into the community:

> *Yes, I was the first one, so we had to sort of, I worked with the midwives within the team and we sort of came up with what would be appropriate and what would be my limits…*
> *(Kate MSW)*

It was apparent from Kate's words that from the very beginning of this new practice, limitations were placed on what tasks the MSWs were able and unable to undertake. Initially the MSWs had a wide remit and undertook a range of tasks, which mirrored the findings of the NHS employer's report (NHS Employers, 2005). However radical changes to the role occurred as the role evolved, which subsequently affected the practices of the MSWs and midwives, as discussed later in this chapter (refer to p.87). Nevertheless, there were a number of activities with which the MSWs could be charged, and Bridget, a midwife, identified the types of jobs she delegated to them:

> *She'd do the blood forms, set the clinic up, and do the blood pressures and take the blood, test urines – that type of thing. She'd also do postnatal visits. So she'd go and weigh babies,*

give support with breastfeeding, any antenatal visits… We had an unexpected BBA [baby born before arrival of midwife/medics] one afternoon, and she actually came along with me while I was there. She helped me open my box and clear up and everything – quite a wide range of things really.
(Bridget MW)

Most of these manual tasks that Bridget outlined could be reckoned to be of a menial nature (or considered tasks), whereas some of the others could be thought of as more complex. Certainly, Kate, the pilot midwife, considered her MSW role to be more than task-orientated and indeed believed the nature of her role to be multifaceted. Kate detailed some of the complex components of her role:

… the breastfeeding, which is something I do support quite a bit in community and again respecting cultures in community, going back to the social problems – being aware of what's appropriate/what's not appropriate, so to speak, as regards, like, what you find in somebody's house…
(Kate MSW)

Kate had been a veteran HCA in the hospital, and now she was the most experienced community MSW. By virtue of her experiences, Kate understood some of the more complicated nuances associated with community working, which she indicated by referring to the social and emotional problems that occurred whilst working with some families. However, there appeared to be disparity between the teams of midwives regarding the MSW role, where one team allowed their MSW to assume responsibility for a particular job, whilst a neighbouring team dictated that the same job was the jurisdiction of the midwife. Negotiations between the practitioner roles can be visualised in the examples I provide of two very similar scenarios where a mother and baby were visited at home, some days after birth, by the team's MSW. In each case, after assessing the baby, the MSWs concluded that each baby required a referral to the hospital paediatrician. In the first case, Helen, the MSW, explained how after contacting a midwife in her team she was able to go ahead and make the necessary referral:

It's like one baby had jaundice and I'm thinking, "This baby has to go to the hospital." I rung paediatric unit… obviously I always ring the midwife to let her know what I'm doing... and she'll say, "Are you alright ringing the paediatric unit?" And this is the midwives having confidence in me, for my assessment of this baby.
(Helen MSW)

Yet, in another team, a similar situation arose and the MSW reported her findings back to the midwife and offered to contact the paediatric team; however, the midwife declined the offer. Heidi, the midwife, considered the responsibility of referring a baby to a medical practitioner not only too onerous for the MSW, but also outside of the MSW's jurisdiction:

I... I've got a memory about a baby who it was obvious needed, uh, to be, uh, assessed in the hospital, and I said to Gillian, "I'll.. I'll come through. I'll come through and have a look at this baby." It was obvious that it needed... And she said, "Do you want me to ring the paeds?" And I said, "No." I... I thought that was not fair on her, because I thought that the paediatrician will... will ask questions that probably Gillian's not capable of answering or, you know. I said,

> *"Oh no, no I don't see that as being..." Not that I was putting her down, but I saw that as my role… But I think it's about me having clear boundaries and Gillian knows them, but I don't know...*
> *(Heidi MW)*

Arguably, both MSWs acted appropriately. The babies' assessments and the MSWs' judgments regarding their conditions were without doubt complex, and whilst one MSW performed and extended her role, the other did not do so. The more complicated and technical an activity may indeed cause it to cross boundaries and impinge on the midwife's role, as highlighted by Heidi. Across the town, differences can be seen in how the MSWs functioned and carried out their role. It appeared the type of work delegated to them was influenced not only by the team of midwives with whom they worked but also varied according to which midwife they were working alongside on a daily basis. It appeared each midwife undertook individual assessments of the MSWs' capabilities and measured these against the task/work that needed to be carried out. The data suggested there was a general consensus between the midwives about assigning certain activities, with some deemed more suitable than others, whilst others warranted the individual judgement of the midwife involved, as demonstrated in these two scenarios. Certainly, disparities occurred as a result of the decisions made by the midwives and teams of midwives, and furthermore they were responsible for blurring the boundaries between the MSW and midwife roles. Moreover, this practice caused the practitioners to question whether any clear boundaries existed that defined where one role stopped and the other one started. This may have led to the practitioners, particularly the midwives, feeling insecure, under-confident and may have possibly affected some of the relationships they developed with the MSWs.

In an attempt to define the difference between her role as an MSW and that of the midwife, Gillian offered what she saw was a clear example of work that lay outside the scope of her MSW skills:

> *What wouldn't I do? Uh, I wouldn't... I wouldn't advise the lady on anything that wasn't... that I wasn't sure about. I wouldn't... I wouldn't even give her a date [estimate the due date of birth of the pregnant woman], you know, because at the end of the day that's not my job to do that, is it, you know?*
> *(Gillian MSW)*

Later in her interview, Gillian again raised the inherent differences between the two practitioner roles. She attached an element of "knowing" and referred to them as *'it's just something that I feel'*, thus suggesting that intuition was partly responsible for creating some of these margins. This aligns with Belenky et al.'s (1986) concept of constructed knowledge and women's cognitive development, which is not merely reliant on the formal educational processes they have experienced. In defining "knowing" her boundaries and her own jurisdiction, Gillian also resoundingly denied that she sought to occupy the midwife's role:

> *… it's just something that I feel, and also I think you need to know your own limitations. I'm not saying I'm only a midwife support worker, 'cause I enjoy me job and I think I've got a good job and I play a good part, but I'm not a midwife.*
> *(Gillian MSW)*

This instinctive "knowing" response appeared to be a common reaction across the groups. Moreover, the MSWs wanted to assure the midwives they were not employed to take over their practice; the emphasis of what they were employed to do lay in their title "support worker." Bridget also provided comparisons between the two roles and explained her rationale for MSWs not being able to carry out particular types of tasks:

> *A midwife is much more of an educator. Her role is much more communicating with parents giving ongoing advice, alleviating their worries and fears and explaining why things are done and what could go wrong if something happens, whereas the healthcare may not be able to … because the knowledge – it's more they're learnt by skill not implications of what if, say, you've got somebody whose blood pressure is high. They know it's high, because they are taught to recognise that that blood pressure is high, but the other implications that high blood pressure can have on pregnancy or the woman herself or her health…*
> *(Bridget MW)*

Bridget suggested that it was the knowledge behind the skills that prevented the MSWs from functioning at a similar level to a midwife. Certainly, Bridget had in point of fact referred to and outlined the jurisdiction of an MSW and that of a midwife, the former being considered an occupation and the latter a profession. An interpretation of the midwives' words was that perhaps they were safeguarding their role and used demarcation measures to delineate this practice and maintain working jurisdictions between themselves and the MSWs. Helen, an MSW, was of a similar opinion. She too believed that MSWs had a certain skillset and were knowledgeable up to a point, but then she implied that thereafter the care of the woman and her family came under the jurisdiction of the midwife:

> *I look at it that that is the midwife role and we're only trained to a certain level and through years of hospital experience and gaining all this knowledge…*
> *(Helen MSW)*

Clearly, in this study, the midwives attempted to assert themselves in jurisdictional matters in a bid to maintain areas of midwifery practice. Simultaneously, MSWs could be seen to be attempting to carve out an area of practice for themselves and negotiate their own boundaries.

When the MSWs appeared to have settled into their community posts, noticeable changes occurred in their role. Both practitioner groups witnessed these changes, some more than others. It seemed that this change was particularly noticeable in one team in comparison to the others, notably the training team. The MSW in this team was Alex, who was the youngest and least experienced community MSW and was the last MSW to join the community. Initially, she was apprenticed to Kate, the pilot MSW. As she began working in an unsupervised capacity, Alex attempted to model her practice on that of her mentor and *'follow in her footsteps'.* Alex recalled how this experience influenced her working practices and outlined what she believed were the expectations of her MSW role:

> *… all these variety of things, making clinics and doing all the visits, and she could have quite a lot of visits in a day. I mean, sometimes working over five o'clock [end of shift] and this is what I followed…*
> *(Alex MSW)*

Alex admitted to being overburdened and felt *'quite bogged down with work'* delegated by her team midwives. Certainly, she found it difficult trying to fit everything in to her working day as she tried to *'cram a lot in nine to five'.* Furthermore, she felt she could not mention her difficulties to any of her team members, and she had even thought of leaving the service. However, Alex did eventually approach a member of the team, but only as a result of seeking advice from family. She assessed individual midwives in the team regarding their ability to support and maintain confidentiality, as she needed to feel reassured, *'to know that that person's not going to go and tell the rest of the team, you know, what I think really'.* Alex identified one such midwife and disclosed to her the difficulties she had in managing her day-to-day activities. This midwife became Alex's mentor and confidante and assisted in the process of altering the MSW role from one that performed a wide range of tasks to one that became focused on supporting breastfeeding. At around the same time, promoting and supporting breastfeeding was one of the key drivers in NHS maternity services and certainly factored in changing the focus of the MSW role. There was no mention in the interviews how this information reached the other teams, although somehow Frankie, another midwife, did become aware, noted the changes and explained the effect they had on the MSWs' practice:

> *... they were actually as midwife support, but the role seems to have changed. It's evolved, I think, since they first came out… She [the MSW] seems to be more working with the women. The emphasis at the moment is on breastfeeding and supporting women who are breastfeeding.*
> *(Frankie MW)*

It was apparent that the employing organisation actively endorsed this role modification, as Alex remarked on the lengthy discussions that had taken place in her local team meetings about the MSW role *'until people actually understood it better'.* Nevertheless, it appeared that this information did not reach all relevant parties, as Wendy, a midwife in the same team, recalled:

> *I was way out of the area, rang the support worker and said, "Are you free to just go and check this lady's blood pressure for me?" So then I got a phone call from one of my colleagues to say did I know that she wasn't doing that any longer. We were to be using the midwife support worker just as breastfeeding support, and checking blood pressures wasn't in her role anymore.*
> *(Wendy MW)*

The lack of communication appeared to upset some midwives, such as Wendy, who *'felt a little bit… not bullied, but as if you will do this'* and *'just felt all of a sudden that the role had changed'* and had had to adjust her working to accommodate the modified role of the MSW. Supporting breastfeeding and its promotion became a large part of the MSWs' remit, and whilst for Alex the modified MSW role was beneficial in lightening her workload and she *'liked this type of role that they've changed it round to',* it also brought with it new challenges which she approached with newfound confidence interpreted

from the positivity she exuded whilst imparting this information, detected by using VCRM. Alex also appreciated the difficulties these changes created for the midwives. The midwives were not only required to adjust their thinking about what work they could or could not allocate the MSWs, but they also had to amend their own working practices to accommodate the extra work created and undertake work which was once part of the MSW role, as noted by Alex:

> *… I think it was, for some people it was very difficult to change my role around, because they were very used to having a healthcare who did a variety of things and then it's gone to a MSW who focuses more on one thing really but then works in a variety of buildings and settings to support that with different skills…*
> *(Alex MSW)*

The other MSWs did not highlight this shift in working arrangements in their interviews, as it seemed not to have been as pivotal as it had been for Alex. It appeared they acknowledged and accommodated the changes in their day-to-day practices without too much forethought.

Matters of jurisdictional working undoubtedly link to the limitation and boundary working of the two sets of practitioners. The MSWs were attempting to establish a practice for themselves, whilst the midwives were intent on maintaining jurisdiction over theirs and the MSWs' practices. The midwives retained control through the use of the professional closure measures available to them, whilst the MSWs tried to instil confidence and assure the midwives they did not want to be midwives themselves.

Gatekeeping

On the whole, the midwives decided what work was appropriate to delegate to the MSWs. This was certainly perceived to be the case by the MSWs. Hannah, a midwife, provided an example of the midwives' strategies as they attempted to build their confidence in the MSWs' capabilities before "allowing" them to work without close supervision:

> *… being supervised, fully supervised in a way. Uh, doing blood pressures, doing bloods, us watching. You know and then you know that she... Once you know and feel that she's competent and she feels confident, then you're happy to let her run with that, you know?*
> *(Hannah MW)*

Hannah's remarks implied the midwives did indeed assess the suitability of jobs and matched them to the abilities of the MSWs, indicating they in fact used "gatekeeping" practices to control and negotiate the work of the MSWs. Furthermore, Hannah suggested these assessments were achieved by midwives directly observing MSWs working in a supervised setting. These gatekeeping practices have been noted to occur in other areas of midwifery services (Curtis et al., 2007) where midwives "allowed" or "gave permission" for other services (in the case of Curtis et al., breastfeeding peer supporters) to contact women included in the midwives' caseloads.

It appeared that each midwife undertook their own individual assessment of the MSW in their team. At no time throughout the interview process were any formal discussions or collaborations noted between the midwives which identified what type of work was appropriate to delegate to the MSWs, although that is not to say it did not happen. There appeared to be a number of factors that influenced the decision as to whether to pass work on to an MSW, and it could be argued that it was not always about gatekeeping. There is a fine line between gatekeeping and delegation practices, as both are measures of exclusionary strategies, and whilst they are also methods of controlling access, arguably delegation is a more ethical practice than gatekeeping. There appeared to be no cut-off point, and one practice therefore blurred into another. Furthermore, delegation for the midwife involved added responsibilities, *'as they are accountable for the appropriateness of the delegation'* (NMC, 2010), which relates back to the basic themes of registration and accountability (refer to p.72).

The MSWs had general principles to follow, such as they must be suitably trained, keep records of training and have written evidence of competence, preferably against a recognised standard (RCN, 2008). In accordance with the NMC code and RCN principles, the MSWs had reached nationally recognised levels of competency and acquired NVQ certification. However, it seemed the midwives exacted their own standards and principles, which may account for variations in the amount and type of work delegated to the MSWs. The complexities of delegating work were discussed by Frankie, a midwife, who reported being overburdened with work and faced adding yet another visit to her working day, which was already crammed with visits. Frankie debated with herself whether or not to pass the extra visit on to the MSW in her team, but then she found herself questioning her decision:

> *… you know if... you know, you've already got eight visits [to clients in their homes] in your book and if you add just put a pop-in visit to her, that's a... you know, another one in your book, but, you know, like,... like Helen [the MSW] could just pop in… And it's things like that you do, but you do that, but then, you know, should it be Helen or should it be you?*
> *(Frankie MW)*

The midwives weighed up a number of options before they decided to assign work to the MSWs. According to Hannah, another midwife, the reasons behind her decision-making processes appeared to have been influenced by the relationship that had been constructed between herself and the MSW. Hannah rationalised in her own words how she chose to delegate work to the MSW, and she wove together qualities that she believed supported her decision:

> *I think that's just... I think that's just experience in building confidence up and seeing how she works. Working with her in those clinics, you know… she's been out for so long, you know, you trust... trust... trust Helen's judgement, because we know what she's like… 'Cause she's... she's excellent, basically. You know... we know she'll ring us if she's got a concern...*
> *(Hannah MW)*

Hannah highlighted the importance of trust and confidence in the MSW/midwife relationship. It took time to build trust and be confident that the MSW was capable of carrying out a task and would report back any issues arising as a result of undertaking the task. Another aspect of trust is apportioning

control. The midwife in relinquishing control can be considered to be decreasing any existing exclusionary strategies and relaxing demarcationary ones. Wheeler (2001) suggested there was a fine balance to be achieved between delegating too much or too little. In the first instance, the practitioner loses control, while in the second the tasks are not achieved or achieved effectively.

The delegation practices of the midwives indicated that they were lessening their control over their gatekeeping practices, which also had the potential to overload the MSWs with work, as highlighted by Alex. These actions also affected the practice of the midwives, as Hannah reported:

> *Last week, she [Helen, the MSW] rang me. She was supposed to be at the breastfeeding support group with me. She rang me up and she said, "I've got nine visits, Hannah. I don't know what time I'm gonna get there." I said, "Well just carry on; you know I'll get everything out."*
> *(Hannah MW)*

It appeared that although the midwives were initially hesitant in allocating work to the MSWs, this hesitancy relaxed as the practitioners negotiated their roles and working practices. Clearly, there were many factors that influenced a midwife's decision to delegate work to an MSW, such as understanding the MSW's knowledge, the midwife's accountability responsibilities and her confidence in the MSW's competence and her limitations, not to mention the matters of trust or the midwife's attitude.

The MSWs appeared to experience a range of attitudes and acceptance amongst the midwives regarding their role. Carmel found that whilst some were *'very lovely and helpful and considerate'*, others were not so accommodating. One particular midwife seemed extremely unwilling to utilise Carmel's support worker skills, and Carmel outlined her experience when working with this same midwife in a clinic setting:

> *That first few weeks I started… I thought it was awful. I had to... "Oh no, you can't do that, Carmel, I'll write it... You can't take that... You can't do that." I thought, "I've been doing this for years, you know, what's the matter with you?" I thought ok, I'll just do blood pressure and wees [urine testing]…*
> *(Carmel MSW)*

This was the beginning of an episode in Carmel's working life that would have far-reaching effects on her personally, physically and emotionally. Carmel's account indicated that she adjusted her work to accommodate the midwife in an attempt to temper their working relationship. Later, Carmel found herself once again facing this same midwife's attitude of indifference. Carmel recounted the occasion when she offered help to the midwife, who was in fact bemoaning her own increased working conditions:

> *I'm not saying she's... she's probably a very good... very good with everything that she does, but I feel that she's, uh... thinks she can do everybody's job, everybody's work, she doesn't need no help and that's it and she's fine. She'll moan about it day after day and say, "I had all*

these visits to do yesterday." I said, "Why didn't you ask me? I would have done..." She said, "Yeah, but they're all... they're all mine... they're all mine... they're all mine." That's what you get, "They're all mine." "Never mind, Carmel. They're all mine."
(Carmel MSW)

Initially, it appeared that Carmel attempted to rationalise the midwife's attitude and actions, but then she revealed her own frustrations by stating the midwife believed she could *'do everybody's job, everybody's work',* which indicated to Carmel the midwife did not feel able to delegate work to others. Carmel recollected the midwife's persistent complaining about her heavy workload, and yet all the while she rejected Carmel's offers of help; consequently, Carmel concluded that the midwife *'doesn't need no help'.* Finally, Carmel recalled the exacting words of the midwife and how she referred to the clients as 'they're all mine'. The midwife's words, repeated by Carmel, implied that she – and only she – retained control of "her" clients' care, thereby disabling the MSWs access to any of the midwife's clients, which left Carmel in no doubt that her services were not required and would not be used. At this point of the interview, Carmel's voice became barely a whisper as she continued repeating the words of the midwife, 'They're all mine', thus revealing Carmel's obvious distress as she recalled the experience. She repeated these words as if to emphasise their meaning, and in doing so she highlighted her own feelings of insecurity. Furthermore, this situation evidenced that MSWs are powerless in any jurisdictional claims within a midwife's sphere of work, without explicit permission. Carmel's experience was undoubtedly an overt illustration of the gatekeeping practices of one midwife, who was seen to be place limitations on the work of an MSW, thus preventing access to clients. Moreover, it was an extreme example of an exclusionary closure strategy. Alternatively, the midwife's act of oppression could be interpreted as a serious act of bullying (Hadkin & O'Driscoll, 2000), which consequently presented a dilemma for me as the researcher. At the time I inwardly questioned whether I ought to continue or discontinue the interview – should I offer counselling now or later, how would I write up such a distressing account in the future or should I even report Carmel's experiences? In the interim the interview continued; however, its tone changed in response to Carmel's needs as I continued to listen. Eventually, I felt that there was an imperceptible change in my role and the interview verged on a counselling session. Kvale (2007) recommended that researchers are cautious and avoid turning interviews into therapeutic sessions, not only to protect the participants if they are not trained counsellors, but also for the sake of the research. Nevertheless, I used the interview prompt tool to guide and keep the interview focused on the research issues (Appendix 8), and at the end of the session I offered Carmel the details of professional counsellors.

This was an extreme illustration of the gatekeeping and exclusionary practices of one midwife. Nevertheless, for Carmel, it was not an isolated event, because these practices were neither limited to one midwife and nor was Carmel alone in being subjected to such discriminatory practices. Each of the MSWs had also disclosed other incidents of lesser gatekeeping offences, evidenced by the delegation practices of the midwives.

The richness and clarity of the data indicated that the practitioners were empowered to speak their mind about subjects that had undoubtedly created tensions in community midwifery practice. As such, the interviews permitted the unmentionable to become mentionable. The MSWs claimed that boundaries surrounding their role, within which they were "allowed" to operate, did indeed exist, whilst the midwives also acknowledged its presence and even admitted being reliant on the MSWs to maintain and manage the continuance of said boundaries. It is evident that each midwifery team organised the work of the MSW differently to its neighbouring team, and individual midwives controlled the MSWs' activities in dissimilar ways. Certainly, it appeared that the practitioners negotiated the jurisdiction of their work, whilst the boundaries of their practices were constructed arbitrarily and dependent on the competency of the MSW, the confidence of the midwife and whether or not the two sets of practitioners had developed a trusting relationship.

Knowledge

This organising theme related to how the MSWs acquired appropriate and relevant knowledge to be employed in their role in the community. The study offered insights into the MSW and midwives' perceptions of what level of knowledge and understanding MSWs needed, in order to be competent practitioners. The data indicated there were two lines of thought, one that was concerned with the MSWs' formal training and educational requirements, and another concerned with their informal learning and practical experience. Data were organised regarding these two opposing perspectives into two basic themes, entitled "The value and training and education" and "The worth of experience and skills."

The value of training and education

Each of the HCAs who successfully secured a community MSW post had had extensive experience of working on the hospital's maternity wards, except for Alex, who had fast-tracked her training in another part of the hospital and completed her NVQ level 2 training within six months, and *'fancying a change'* applied for a community MSW post. Alex understood the reasons why her application had been unsuccessful, and she explained how she turned this to her advantage:

> *… they obviously couldn't set me on as a healthcare because I hadn't got the background experience, which I understand that now, now that I am out in community, but they did offer me a position as a healthcare on the ward. So I trained up on the ward and got my experience and knowledge from there for about 18 months, and then a position came out in community for a healthcare post and they offered me the position out there.*
> *(Alex MSW)*

Similar to Alex, the other community MSWs had achieved NVQ level 2 training, albeit a number of years earlier. On completing their training they accrued experience in the hospital as HCAs on maternity wards, before any of the new posts became available. The data indicated there was a wide variation in the midwives' comprehension of the training and educational requirements of an MSW.

One of the midwives, Heidi, disclosed her total lack of awareness and simply declared '*I don't know',* although after some procrastination she enquired, *'I think it's on the job, isn't it?'* The rhetorical nature of her answer indicated her uncertainty regarding what was involved in the actual training of an MSW. Other midwives, such as Bridget, recognised that MSWs were *'trained to a certain degree',* but again she appeared unsure of what actually constituted MSW training. However, for Frankie, another of the midwives, the formal education requirements remained wholly unclear:

> *What does concern me about them is that they do not... they've got no formal education, there's nothing that's recognised educationally about healthcares – it's all in-house, and do they have to attend? Is it compulsory?*
> *(Frankie MW)*

Frankie was not convinced that an *'in-house'* training programme (which was how NVQ certification was managed at the time) was as robust as the training of nurses, midwives or other higher educated individuals. Frankie used the preparation of a volunteer breastfeeding counsellor as an example. Similar to breastfeeding counsellors, MSWs often undertook breastfeeding support with mothers and families, and Frankie chose to compare the training of a breastfeeding counsellor to that of an MSW:

> *But you get people, like, who act as advisors for things like the National Childbirth Trust, and look at the education they have to undergo to actually be that advisor [breastfeeding counsellor] for NCT, because they're representing the NCT. Their educational level is phenomenal, isn't it? You know, but we just, like, have worked on a postnatal ward for a couple of years: "Off you go" [referring to an MSW].*
> *(Frankie MW)*

Frankie's words suggested that she devalued and mistrusted the NVQ training the MSWs underwent, and instead she favoured more formal education and training processes, usually associated with recognised educational establishments such as universities. Conversely, another of the midwives, Hannah, acknowledged that NVQ certification did indeed have some worth, and she identified it as a practical-based training package. Hannah related the various levels of NVQ training to the different skills the MSWs had been trained to undertake, which helped to determine the type of work that could be delegated to them:

> *I mean, I don't know that that should come with the level of NVQ that they get to, because obviously depending on what level they're reaching depends on what skills they've got as well – and that depends on what they're gonna do on a day-to-day work basis…*
> *(Hannah MW)*

The majority of the MSWs had trained as HCAs (NVQ-based) a number of years previously. A few of the midwives had moved into community practice even before NVQ certification had been introduced, and therefore they were unfamiliar with NVQ processes and the training objectives of the MSW. Neither, it seemed, had the midwives been offered any information around this subject when the MSWs were placed into their new posts. Clearly, there existed a wide range of understanding amongst the midwives about the education and training of an MSW, which perhaps undermined the

midwives' confidence in the role. Furthermore, data in the form of the midwives' words revealed not only their misunderstandings but also their mistrust of NVQ training. In contrast, the MSWs were quite clear about and knew of the hard work and commitment required to acquire NVQ certification and held their formal educational achievements in high esteem.

The worth of experience and skills

Three of the five MSWs had previously been employed as nursing auxiliaries (NAs) on maternity wards before choosing to undertake NVQ training to become HCAs. During their interviews, the MSWs Kate, Carmel and Helen voluntarily disclosed their own length of service without any prompting, an indication of them valuing their long service (Kessler et al., 2012), a phenomenon that may be considered an altruistic trait. Kate revealed the length of her own NHS service, outlined her personal learning history and subsequently summarised the prerequisite training of MSWs that ensured their knowledge and skills remained up-to-date:

> *I started out as a nursing auxiliary in 1985 and consequently I ended up taking my NVQ level 2. I think it was in 1992 and I passed that, and obviously although the training I've had has been all in-house breastfeeding study days and mandatory study days, and resuscitation and all that kind of experience that comes with training as a healthcare assistant.*
> *(Kate MSW)*

The MSWs considered their ward experience as crucial, believing that it equipped them with the appropriate knowledge and skills upon which they could draw whilst working out in the community. Helen, an MSW, claimed that '*hospital experience... I would say is essential'.* She was not alone in this matter, as Carmel agreed that a background in hospital working was indeed critical in providing the experience to function as a community MSW:

> *... I think you've got to have experience on the ward and that's... You can't just come out here and just think, "This is it"…*
> *(Carmel MSW)*

Carmel's words fervently suggested that she believed ward experience was indeed essential in providing her with the necessary skills and knowledge to work as an MSW. Moreover, she recounted what she had learnt from working on the wards and presented examples of this experiential learning, therefore revealing how she valued the ability to transfer these skills into a community setting:

> *I think the experience on the ward has given me an awful lot of back up really with me job, 'cause I think I wouldn't have learnt about breastfeeding, women's feelings, postnatal depression. All these different things, there's no way I would have picked that up out here – you have to do that in the hospital…*
> *(Carmel MSW)*

In addition to these practical skills, Helen, an MSW, noted skills other than those of a manual nature were just as important a requirement for the role. Helen offered an insight into these particular abilities, but moreover she provided her own rationale as to why they were required:

> *… because I for one, Debbie, think social, you know, experiences are really good, to be able to talk to people. They've* [the MSW] *got to have a good background knowledge of, uh, the jobs they're gonna be asked to do.*
> *(Helen MSW)*

Certainly, social skills were a significant part of community working and assisted in carrying out all manner of tasks. In mentioning social skills, Helen provided a deeper understanding of what else was involved in the work of the MSWs. It is obvious that the MSWs appreciated and depended on their past experiences. Helen truly appreciated the profound amount of education and learning undertaken as a HCA in the hospital, and she offered her own perspective on the matter:

> *… you don't realise until you actually come out into community what knowledge you have…*
> *(Helen MSW)*

The MSWs and midwives agreed that increased length in service did indeed correlate with the acquirement of additional experience. Consequently, these practitioners seemed to sense that the MSWs were therefore equipped with enhanced knowledge and skills. Some of the midwives had had experience of working alongside HCAs in the hospital and expressed an appreciation of the MSWs' long service history, as well as the assumed experience of the MSW. Wendy, a midwife, had recently moved to work in the community and had therefore had recent experience of working alongside HCAs on maternity wards. This placed Wendy in a position to realise how an MSW's increased length in service impacted on them acquiring a deeper understanding of maternity matters. Indeed, she judged veteran HCAs to possess the necessary knowledge and skills that would enable them to function in their MSW role as they commenced work within the community:

> *I mean, since I've been out on community I've worked with MSWs and I've had the opportunity of working with them. One came from the hospital with a lot of experience working with new mums on the postnatal ward, and I felt that benefited her greatly.*
> *(Wendy MW)*

Wendy was not alone in this matter, as Heidi, another midwife who had had no experience of working with HCAs, also believed the experienced HCA to be capable of working as an MSW in the community. Heidi positively valued their accumulated experiences, particularly those of the MSW currently working within the team:

> *We've only ever had Gillian, yeah, and she came from another team, but having previously had lots of experience in the hospital. So she came as quite an experienced healthcare assistant…*
> *(Heidi MW)*

The midwives viewed the ward experience and the building of knowledge and skills of the MSWs as essential in effectively carrying out their work; however, Toni considered other factors and the benefits of having such attributes when working alone in community:

> *I do think it needs a fair bit of... I think community generally needs a fair bit of experience, because there's a considerable amount of lone working, although you're in a team you know there's a fair bit of your work that is lone working and you haven't got somebody just sat next to you that you can say, "What do you think about this?" or "I've got this problem, what shall I do now?"*
> *(Toni MW)*

Toni stressed the importance of the MSWs owning and relying on their accrued knowledge and skills, and she associated these aspects with the competence of the MSW. Furthermore, she pre-emptively thought about what may happen should an inexperienced HCA be employed as a community MSW, and the possible detrimental effects that could follow:

> *… you know you can... you can come across anything, can't you, when you're on your own? Uh, so I do think that you... you need a certain amount of experience and confidence to be able to deal with community work. Uh, and the potential, I suppose, if you're sending out inexperienced support workers onto community is that you could scare them to death, couldn't you?*
> *(Toni MW)*

In Toni's statement it is interesting to look at what was not being said (Oliver et al., 2005). Previously, I had interviewed Carmel, the MSW attached to this team. Carmel spoke in her interview of her team members being aware, but not fully so, of the fateful relationship between herself and another midwife that had affected Carmel's health. In her statement, Toni may have been referring indirectly in part to Carmel, who was in fact experienced in hospital and community work but had been exposed to the challenging exclusionary strategies of one midwife. Alternatively, Toni's statement could be taken at face value and mean exactly what she said, and voiced her concerns about placing inexperienced HCAs in community MSW posts. Later in her interview, Toni did disclose that she knew of some of the difficulties that Carmel had experienced whilst working alongside the midwives in her team.

Alex, an MSW, who had the least amount of experience working on the maternity wards, echoed the views of the other MSWs and midwives. She reflected on how dependent she was on her acquired hospital experience to furnish her with the appropriate knowledge and skills to enable her to function effectively as a community MSW. Furthermore, Alex predicted what may have happened had she not had this experience to draw upon:

> *I mean, if they'd have put out into community with the experience I'd got, I'd have been stumped, I'd have been very, very stumped… I think the ward gave me a lot more confidence and experience with dealing with the public, so that built me confidence there, plus I knew the basics of the healthcare role… I wouldn't have known if they'd have put me out in community without that experience, so it's very, very valuable to be on the ward first and then put out in community – that's what I felt…*
> *(Alex MSW)*

Interestingly, Toni and Alex mentioned in their statements the matter of confidence, and they related this phenomenon to experience. They also observed both of these elements as key attributes in community working, especially in lone or independent working. Principally, they associated consummate knowledge with self-assurance in the development of a competent MSW. Notably, they perceived an MSW's sense of worth or self-esteem influenced their confidence in their ability to become a competent worker.

The data clearly indicated that the MSWs and midwives valued the experience the MSWs had accrued in their roles as HCAs. Both sets of practitioners equated greater experience to increased knowledge and skills, enabling the midwives to feel more assured of the MSWs' abilities to carry out their role. However, the midwives were not so self-assured about MSW training, particularly NVQ certification, and while they were aware of the MSWs' NVQ accreditation, they were uncertain of the training and educational requirements needed to gain the qualification, and therefore they remained sceptical of its 'in-house' aspects. The midwives measured the training and experience of the MSWs against their own educational standards and training and those of other professionals. Conversely, the MSWs were quite clear in that their education pathway had been valuable in equipping them, together with their practical learning experience, to become competent and confident workers.

A matter of confidence

The data revealed the midwives were doubtful about how the new MSW role would work in the community, indicating they were not all confident, whereas the MSWs were much more self-assured. They were armed with their role description and looked forward to their new challenge and the chance to cast off the confines of hospital working. The midwives were uncertain about what work the MSWs could undertake and questioned their own and the MSWs' accountability, evidenced by their hesitancy in delegating work to the MSWs. Furthermore, the midwives were unconvinced about the training and educational processes of the MSWs, preferring to appreciate the MSWs' practical skills and knowledge, which were acquired through their working experiences on maternity wards. In contrast, the MSWs were confident that their formal training and informal experiences had indeed prepared them to work in their new role, in the community. The gatekeeping practices of the midwives were evidenced in the MSWs' accounts, in that they outlined how the midwives controlled and circumscribed the amount and type of work they delegated to the MSWs, further substantiating the midwives' lack of confidence in the MSW role and how they attempted to maintain control of their jurisdictional working. However, the midwives gradually increased the amount and complexity of work they delegated to the MSWs. In lifting their exclusionary practices, the midwives did in fact replace them with demarcationary ones and continued to maintain control of jurisdictional working between themselves and the MSWs. In point of fact, the MSWs related these events to the development of their working relationships. The data revealed a range of working relationships, with some far more challenging than others. On the whole, though, as the role became more accepted by the midwives,

relations between the two sets of practitioners improved. A number of factors influenced the midwives' decisions. These revolved around the midwives' increased confidence in relation to understanding the MSW role and the boundaries constructed between themselves and the MSWs, confidence in the MSWs' knowledge, competencies and proficiency and trusting them to report back accordingly. Confidence developed as a result of the practitioners negotiating their roles and relationships in establishing this new role and its boundaries.

Conclusion to Chapter Four

In this chapter I have reported on the experiences of MSWS and the midwives in an extensive and comprehensive manner. I have used quotations from their interviews to support the analysis of the data, and I have aimed at providing the reader with insights into the lived experiences of the practitioners in a meaningful way. I have also endeavoured to interpret and convey the meanings of their words accurately and truthfully. The key issues were identified through the analysis of their accounts. The MSWs and midwives recognised matters that were significant to them, when integrating the new MSW role into existing community midwifery practices. The midwives were expected to accommodate the role whilst the MSWs were expected to blend in to an established service. At the same time, the practitioners attempted to define and understand this new role. The knowledge and competence of the MSWs was scrutinised by both practitioners. Negotiating roles, defining boundaries and the gatekeeping practices of the midwives proved challenging and affected the relationships between the two cohorts. These matters have been organised into a coherent format (refer to Figure 1 p.67), with the basic and organising themes supporting the overall global theme of confidence. These issues are considered and discussed more fully in the next chapter.

In the next chapter I discuss the key findings more fully in light of the aims of the study. The discussion is structured around the organising and basic themes that are outlined at the beginning of this chapter. These themes have been identified by the MSWs and midwives as the most significant issues that influenced the integration of the MSW role into this community midwifery practice and presented the greatest challenges. The strengths and limitations of the study are also outlined. To conclude the chapter I draw some historic parallels with this study and its findings.

Reflections of the researcher

In essence, this was probably the hardest chapter to write. Overall, I sought to do justice to the voices of the MSWs and midwives and truthfully interpret the meanings behind their words. Furthermore, I wanted to make the issues that were significant to them significant to the study, as this research revolved around their experiences of their relationships with each other. Using Mauthner and Doucet's (1998) VCRM was invaluable, as it enabled me to hear more clearly the voices of the MSWs and midwives, which in turn undoubtedly assisted with the interpretation. I was challenged by the amount of data I had gathered, and I found difficulty in assessing what data I ought to include in the write up

of the study. Moreover, I questioned whether it would be acceptable to place into the public domain what the MSWs and midwives disclosed in their interviews, particularly the more harrowing narratives.

CHAPTER FIVE

<u>Discussion of the Findings</u>

This chapter presents a discussion of the key findings of this study, the aims of which are highlighted once again and a discussion on which centres around the organising and basic themes identified when analysing the data. This research has revealed some of the difficulties encountered by MSWs and midwives when establishing a new way of working, as well as the challenges they faced as new working relationships developed. The data also highlighted their personal struggles as they endeavoured to define spheres of working to safeguard the future of their own practices. I conclude the chapter by providing a number of historical parallels that can be aligned with the present-day relationships between the MSWs and midwives.

This research aimed at exploring the working relationships between MSWs and midwives. In the process, their perceptions of the MSW role and its boundaries were included for examination. As one of the aims was to review the development of the role of an MSW, it seemed logical to use an introductory interview question about the knowledge and skills the MSW brought to this new role. The findings revealed that the overarching or global theme of the study was confidence, namely the midwives' confidence in the MSWs and the MSWs' confidence in their own practice. The organising themes that emerged to support the global theme were "Role," "Knowledge," "Boundaries" and "Relationships." The significant issues originating from the data and underpinning the organising themes were arranged into basic themes (see Figure 1. p.67). Subsequently, this chapter has been structured to reflect these same themes.

Confidence around roles

One of the challenges that confronted the MSWs and midwives when faced with integrating a new role into an established service was that there had been no precedent on how to approach such a challenge. A review of the research at the time indicated that there were no existing support mechanisms such as national, regional or professional policies or guidelines to address these changes within either the employing organisation where the study took place or any similar organisations across the UK. Since this research has been undertaken there have been a number of reports and other research studies undertaken to explore the MSW role (NHS Employers, 2006; Bach et al., 2008; Moran et al. 2010) and working practices (Moran et al., 2012). Therefore, the MSWs and midwives found themselves managing these changes as individuals on a practical day-to-day basis. The midwives also felt under-confident and frustrated by the lack of preparation, communication and managerial guidance in accommodating the facilitation of this new role, evidenced by them requesting access to the MSW role description to enable them to better manage its integration. As Muller-Smith (1997) noted, our formative learning (school/college) has not equipped us to share knowledge or

problem solve within a group, but then I appreciate that neither has our employing organisation enabled us to assume such responsibilities in the workplace.

"Rocking the boat" and "calming the waters"

The findings revealed the excitement of the MSWs as they revelled in the idea of a new role that would bring with it new challenges. These included the opportunity of progressing up to NVQ level 3 and possibly extending their skills accompanied by a rise in wages, but just as important was the chance to work office hours and be rid of the grind of working shifts. On the other hand, the findings indicated that the mention of implementing an assistant role into the community incited different thoughts and feelings in the midwives. According to one midwife (see Heidi p.69), there was a fifty-fifty split, whereby half of the community midwives welcomed MSW assistance whilst the other half recoiled from the idea and instead favoured their own autonomy. Later in this chapter I consider that all the midwives were indeed wary, even those that declared their openness about the role. In fact, the MSWs were aware of the midwives' uncertainties around the role and therefore employed different tactics in an attempt to maintain equilibrium in their relationships.

What exactly is the role of the MSW?

Defining the MSW role was a contentious issue for the midwives. They agreed that at the beginning of these new changes they would have appreciated guidance to assist with the integration of the MSW role into the community. Furthermore, they identified that an essential tool to assist them in this matter was indeed the MSWs' role description. They believed this would benefit them inasmuch that it would inform them of appropriate tasks to delegate to the MSWs. However, in the event of integrating the role into the community, the role description remained elusive by its absence, and it was cited as a concern by all the midwives. Whilst the midwives reported receiving nothing, the MSWs were in fact provided with a copy of their role description when they applied for and/or secured an MSW post. The findings indicated the MSWs operated at different levels, and as a result there were inconsistencies in the provision of midwifery services (see Helen p.84 and Heidi p.85). Moreover, the findings revealed the disparate experiences of the MSWs and illustrated that they had been subjected to professional closure strategies (Witz, 1992) ranging from marginal to extreme. The provision of a role description to both sets of practitioners may have assisted in providing a uniform and consistent midwifery service in the community. It may also have facilitated creating homogenous experiences for the workers involved, and possibly avoided some of the disparate experiences of the MSWs. Furthermore, the absence of a "black and white" written copy further undermined the midwives' confidence, but it also suggested that there lacked an apparent exchange of communication between the organisation and its employees, a phenomenon considered essential when negotiating change (Bate et al., 2004).

Across the UK there is disparity in the job titles of assistant roles in healthcare – it seems there is interchangeable use of the terms "assistant" and "associate" (DH, 2006; Wakefield et al., 2009; RCN,

2010). In this Trust the terms "midwifery" and "maternity" also had a tendency to be swapped around. Neither is there any consistent job description for assistant roles nationally, and it is known to vary from Trust to Trust (Wakefield et al., 2009). Wakefield (2009) recommends that due care and attention should be taken when composing job descriptions, as poorly defined role descriptions create difficulties around the duties of responsibility and accountability, whilst restrictive ones may oppress the workers who use them.

Whose registration? Whose accountability?

Only the midwives were concerned about the MSWs' registration status and accountability. However, the MSWs indicated that they were aware of and hinted at the matter during their interviews (see Helen p.86). To date, MSWs in the UK are not required to register their qualifications with any formal body, unlike midwives and nurses, and therefore they are not subjected to the same forms of governance as nurses and midwives. The call for regulation is in fact a UK-wide issue that concerns patient safety and standards (McKenna et al., 2004). The facts that MSWs are unregulated and NVQ processes have yet to gain university affiliation are possibly some of the reasons why the MSW role has not gained professional status and remains an occupation. Certainly, Griffiths et al. (2010) raised urgent questions directed towards the NMC, as assistant roles pose potential safety risks to the public whilst they remain unregulated and unregistered.

This argument is fuelled further by this study, as accountability has repercussions for both MSWs and midwives. The midwives were confused about who held accountability for the MSWs and their actions – the MSWs, the midwives or the employing organisation – thus aligning with the findings of the RCN's (2010) assistant practitioner scoping project. The midwives were not at all confident in this matter and did not realise that in point of fact they were only 'accountable *for the appropriateness of the delegation'*, although they *'must ensure that the person who does the work is able to do it and provide adequate supervision and support',* as recommended by the Nursing and Midwifery Council (NMC, 2004). However, the MSWs were aware of but did not raise the issue as a concern for them. Therefore, it raises the questions as to whether they were truly unaware of their responsibilities, did they choose to ignore the issue or was it that they neglected to mention the matter in their accounts?

Confidence around relationships

The findings from this study indicated that the relationships between the practitioners varied across the service and were related to their confidence in the roles and boundaries they defined and negotiated. Most of the midwives had been working in the community for a number of years as autonomous practitioners and had not had the opportunity to work alongside HCAs, a phenomenon that is now commonplace in the hospital environment. The move to integrate an assistant role into the community setting added new responsibilities to the midwives' practice. This involved assessing the MSWs skills and competencies to ensure safe delegation of work (NMC, 2004; RCN, 2011) whilst

simultaneously striving to build new professional relationships. Likewise, the MSWs also had multiple challenges that included adjusting to a new environment, acquiring new skills and defining a new role whilst also developing new relationships.

Heading in a new direction

The findings revealed the midwives' cautiousness as the MSW role was introduced into the community. The midwives were uncertain and lacked confidence about a whole range of aspects regarding the role. These included the MSWs' skills, abilities, experience and what work they could be delegated, but overall they were uncertain about the person with whom they were expected to construct a working relationship. The midwives placed equal importance on getting to know the person as much as they did their knowledge and skills. The MSWs sensed their hesitancy and under-confidence and used a number of ploys to assuage the midwives and build their confidence in the MSW role. One of these approaches involved using mobile phones. The practitioners spoke in equal measure about how invaluable mobile phones were to keeping in touch with each other. This tool assisted in the construction of their relationships and enabled a two-way checking system whereby the MSWs could check what they had done was correct but also report their findings to the midwives, whilst the midwives could check the competencies of the MSWs and whether they had delegated work appropriately. MSWs and midwives reported that the number of calls reduced over time. The MSWs recognised they were gathering new knowledge and learning new skills and their confidence increased, evidenced by them not needing to check or report every detail to the midwives. Similarly, the midwives realised the MSWs were indeed competent practitioners and knew their own limitations, which in turn increased their confidence in the MSWs, evidenced by the rise in the amount of work they delegated to the MSWs. Effectively, the practitioners began to construct working relationships with each other through this negotiation of their working practices.

Harbouring suspicions

Initially, all the midwives harboured suspicions around how the MSW would benefit themselves, community midwifery practice and women and their families. On a practical basis, how would the role fit in to their day-to-day midwifery practice, how would they cope with the extra workload of assessing competencies and delegating work or how would they know what work to delegate? This extra work posed by the role is cited by Kessler (2012) as another concern when working alongside ancillary workers.

Furthermore, the midwives voiced their concerns over what they saw as the potential erosion of their role and the prospect of introducing the MSW role as a cost-cutting strategy. Griffin et al. (2011) found maternity care support workers (MCSWs, the Scottish equivalent of MSWs) reported similar worries of suspicious midwives, as seemingly they did not see the need for such a role in maternity services. Some of the midwives in this study viewed the delegation of tasks as somehow eroding the role of the

midwife, while others saw assigning less complex tasks to MSWs as giving away the "nice" parts of the job (see Frankie p.78), which they considered to balance the more complex roles they were required to undertake. Although the midwives also recognised the "nice" tasks required time spent on them, for example by supporting breastfeeding and teaching families about caring for their babies, they acknowledged that midwives' time was considered an expensive commodity, in a time when staff were demanded to work smarter to save on NHS spending (Parish, 2008), which formed part of their suspicions. The midwives were aware that there was a real possibility that MSWs could ultimately usurp the role of the midwife, replacing the midwife with an MSW, particularly in caring for women and their families in the postnatal period, where maternity services could potentially move to a similar system currently operating in Scandinavian countries (Wiegers, 2009). It can be interpreted that the midwives demarcated the boundaries by way of delegation between themselves and the MSWs as a means of power and control, as defined by Johnson (1972), to avoid them being replaced by MSWs.

As a result of the midwives' suspicions, all the MSWs had been subjected to professional closure strategies, evidenced by the type and amount of work delegated to them. As part of the midwives' strategies a significant challenge for the MSWs was the attitudes of the midwives regarding the MSW role, something the MSWs saw as pivotal to the success of integrating their new role into the midwifery community service. This was evidenced by the MSWs *'not wanting to overstep that line'*, using mobile phones to negotiate the boundaries between themselves and the midwives, knowing *'that line is only a phone call away'*. In defence of their professional closure strategies the midwives were struggling to adjust to this new way of working too, trying to balance delegation with safety (see Toni p.73). The professional strategies employed by the midwives resulted in them behaving oppressively towards the MSWs. The findings indicated all the MSWs had experienced the oppressive behaviour of the midwives to varying degrees as a consequence of the midwives' attitudes and practices, which were the result of feeling undermined by the role. Some MSWs sought to rationalise the midwives' manipulative behaviour and countenance their actions. As mentioned, one MSW (see Carmel p.77 and p.90) found herself subjected to episodes of repeated subjugation at the hands of one midwife, eventually removing herself from the environment to avoid further subjugation and safeguard her health and mental well-being. Other MSWs found the workload overwhelming, with another MSW (see Alex p.87) revealing she felt oppressed by the attitudes of the midwives in their inability to recognise her struggle to manage the work. This oppression stopped her from approaching the midwives to tell them of her struggle, and she only felt enabled to do so after seeking advice from family members. As a result of Alex's experience, and the key NHS drivers around breastfeeding, the practitioners renegotiated the practices of all the MSWs and subsequently their role became focused on supporting breastfeeding mothers.

Leaving suspicions behind

Over time, working relationships evolved and began to improve, and the MSWs reported feeling appreciated by the midwives, as the midwives missed them when they were absent due to holidays,

training or days off. However, there were some midwives who admitted not feeling affected by the changes, with one feeling safe from these changes in her *'own little bubble'*. This was a midwife (see Bridget p.80) whose team had been without an MSW for some time. There were other midwives who reportedly *'defied the MSWs' existence'* and who chose not to work directly with the MSW until they were called upon to do so by another midwife and the MSW. A plan was hatched to ensure the "reluctant" midwife and MSW (see Heidi p.80 and Gillian p.79) worked together. After this experience the "reluctant" midwife stated she *'can't do without her now'*, thereby aligning with McKenna and Hasson's (2002) notion that nurses are thankful for the assistance of a support worker. Indeed, the findings highlighted a number of factors affected the overall positive changes in the practitioners' working relationships. The midwives needed to understand and feel confident about aspects of the MSW role that included its limitations and the boundaries between the practitioner roles, being assured of the MSWs' competencies and confident in their proficiency and trusting them to report back, particularly matters warranting the attention of the midwife. The findings revealed that in constructing relationships there was a reciprocal relationship between trust that built up between the two sets of practitioners. This was highlighted by those who spoke of trust in good measure in relation to the MSWs' capabilities and them working within the boundaries negotiated between themselves and the midwives, as well as getting to know the person (see Gillian p.81 and Heidi p.81). Indeed, the findings revealed that whilst most relationships shifted and improved, some relationships flourished, shown by the midwives of the MSWs stating that '*we're gonna get married*' and '*we can't live without them*'. However, there were those realtionships at the opposite end of the spectrum that would never thrive.

Mothers and their children

Some points of view did not fit with any of the other findings, as they were just so very different, but neither were they from a singular source. These different impressions came from MSWs and midwives who likened the relationships between practitioners to those of a mother and child (see Wendy p.82 and Kate p.83). The older, more experienced MSWs were seen to mother the midwives in their teams and acted as a conduit between team members, whereas the younger, less experienced MSWs needed to be cared for and nurtured. Muller-Smith (1997) compares being part of a team, fitting in and being part of an organisation with the idea of creating a family atmosphere where loyalty and longevity are rewarded through the assurance of being looked after, which aligns with the findings of this study.

Confidence around boundaries

According to the findings there was no clear process for delegating work to the MSWs. Therefore, each midwife personally undertook an assessment of the competency of the MSW allocated to their team, and then delegated work they considered the MSW was able to manage. This was evidenced in the accounts of the MSWs who found that the type and number of tasks they undertook depended

upon which midwives they happened to be working alongside on any given day. The midwives' rationale for their actions included needing to be assured that the MSWs were indeed competent to carry out any given tasks. This assurance was achieved in the first instance through the midwives supervising the MSWs while carrying out the required task, before then being "allowed" to carry out the task unsupervised. One of the midwives (see Toni p.73) identified similarities between the teaching and learning of student midwives, something that is touched upon in Brennan and McSherry's (2007) study and how accountability is managed for student nurses working as HCAs. In part, the midwives operated according to the NMC's code regarding accountability (NMC, 2010). However, the employing organisation, the Trust, had effectively assumed this assessment by employing the MSW. As a result of these individual assessments of the MSWs' competence by the midwives, the findings in fact revealed that the MSWs were functioning at different levels. This was not only according to the team within which they worked, as neighbouring teams operated in dissimilar ways, but also according to which midwife they worked alongside on any given day, and in consequence the MSWs were frequently required to adapt their practice, often on a daily basis.

Furthermore, the findings indicated that the midwives felt further reassured as the MSWs reported back to them on the success and completion of the task, and also by highlighting any further concerns or work that required the attention of a midwife. This reporting procedure appeared to have a twofold effect; the first in that the midwife was informed that the task had been competently completed and therefore the midwife remained in control of the task, and the second in that the MSWs believed the midwives appreciated this type of communication but more crucially saw it as a mechanism upon which to build better working relationships between themselves and the midwives. In essence, the practitioners were negotiating their roles and boundaries, dependent on the trust and confidence they had built in the development of their relationships.

Matters of negotiation

Jurisdictional matters were another of the practitioners' concerns revealed in the findings. The MSWs were indeed aware of their own limitations and very clear about their own role and boundaries. Furthermore, they were certain of the fact that they would not overstep "that line," and they recognised that they had not the midwifery training that was necessary to become a midwife. Initially, the midwives were not confident about the MSWs' skills and competencies and were unsure about what tasks could be delegated appropriately. In time, however, the midwives became more confident in passing work to the MSWs, having assessed their skills and experienced their working and been assured that the MSWs were actually aware of their own limitations. The midwives considered this process could have been assisted by the provision of the MSW role description, as already outlined. However, the findings did in fact reveal occasions where the margins of both roles were blurred, highlighted by the conflicting views of midwives and MSWs operating in two different teams but managing a similar scenario, where one MSW was "permitted" to extend her role whilst the other MSW was not "allowed" to practice in the same manner (see Helen p.84 and Heidi p.85).

The most experienced MSWs were indeed knowledgeable about their role and certain of their boundaries, which they demonstrated on completing their apprenticeship in the training team when they were allocated to a different team of midwives to work alongside. The accounts of the MSWs demonstrated their assertiveness, when they informed the midwives of what abilities and skills they had acquired, what tasks they were deemed competent to undertake plus those they believed to outside their jurisdiction and in the sphere of the midwife (see Kate p.72).

The MSW role did in fact change after evaluation by the training team. These modifications affected the MSWs' practice and boundaries and were negotiated partly in response to the needs of Alex (see Alex p.87), an MSW who reported she was finding difficulties in managing the workload, but moreover a reaction to the then current NHS key drivers directing maternity services at the time. Maternity services were being directed by Standard 11 of the NSF Children and Young People Plan (DH, 2004) to provide flexible services to fit around the woman and her baby, prioritising care for the vulnerable and disadvantaged, placing emphasis on the provision of good psychological outcomes and urging extending individualised care to women by offering choices (DH, 2006). The CEMACH report (2007) proposed that antenatal care could be accessed easily by all women early in pregnancy, to offer support and care for those who posed a high risk. NICE had also developed a postnatal guideline (2006) and later, an antenatal one (2008a) recommending best practice, ensuring women received information and choices about their care, including breastfeeding support and information. Bolling et al. (2007) published the five-yearly breastfeeding survey and advised that maternity services address the inequality issues highlighted in the report.

Accordingly, the MSW role was renegotiated to focus on promoting and supporting breastfeeding. In effect, the MSWs' remit became restricted and the midwives were limited to the type of work they could delegate to the MSW. This caused confusion and frustration, not only between the other team midwives but also the neighbouring midwifery teams, as seemingly 'the goalposts had moved'. Difficulties arose partly due to a lack of communication between team members, but also some midwives considered this alteration in service to have accommodated the concerns of one MSW, whereas her predecessors had had no complaints. However, other midwives did in fact recognise the wider picture, noticed other changes that took place at around the same time and took account of UK national guidelines that required maternity services to be involved proactively in supporting breastfeeding (Renfrew et al., 2005). As a result, the MSWs and midwives were once again expected to accommodate these further changes and adapt their working practices. There was also the case of Carmel, an MSW (see Carmel p.77 and p.90), who found herself subjected to some extreme gatekeeping practices where no amount of negotiation of her role brought about any change in her relationship with the midwife.

Issues of gatekeeping

The gatekeeping practices used by midwives were seemingly in response to a perceived threat of displacement. Subsequently, they guarded against their vulnerability by controlling the activities of the MSWs. Indeed, the erosion or even eradication of the midwifery role was a key consideration in deciding what work to hand over to the MSW. The midwives were noted to use exclusionary strategies, in order to monopolise skills they were confident only a midwife was capable of managing. In doing so, they demonstrated the downward oppression of the MSWs and their role. The findings indicated varying degrees of control, with some midwives seeming to delegate tasks freely, whilst others were more cautious. There were also those who were extremely reluctant to relinquish any control over their work unless they were prevailed upon to do so. This issue of delegation is not unique to midwifery. Nancarrow and Borthwick (2005) reported that professional staff were also unwilling to "give up" tasks when public sector funding was pressured and job security was questioned. Furthermore, Bosley and Dale's (2008) study noted nurses in general practice resisted delegating practical tasks to HCAs, due to a perceived sense of threat to their professional identity, with Lindsay (2004) reporting similar concerns of midwives around the erosion of their role following the introduction of MSWs to Addenbrookes Hospital in 2003.

Midwives have celebrated the autonomous nature of their role for over a century. Prior to the midwifery profession becoming statute, midwives themselves had been subjected to exclusionary and demarcationary strategies (Kreckel, 1980; Witz, 1992) meted out by patriarchal groups that included the state, the Church and the medical profession (MacDonald, 1995; Kent, 2000). The midwives used similar strategies to control and circumscribe the practice of the MSWs and appeared reluctant to delegate work. Initially, it seems the midwives used downward exclusionary strategies, from profession to occupation, thus effectively disabling the MSWs' practice. Then, as the midwives' confidence grew in the competencies of the MSWs, they lifted this exclusionary practice only to replace it with a horizontal demarcationary approach. This strategy was more about inter-occupational control between spheres of practice, and it lent a sense of respect to each other's jurisdiction, similar to the current practices of midwives and medical men. The situations that dictated how the midwives released control included increased workload, holiday times and days off; otherwise, work would fail to be completed and impact on the care of women and their babies (see Frankie p.89). The MSWs spoke not only of how differently each midwife worked, but also how they were required to adjust their working according to the demands of the midwife they worked alongside, in order to maintain a good working relationship. Certainly, the findings revealed that the midwives as gatekeepers (Curtis et al., 2007) decided what work, if any, to assign to the MSWs. Some of the midwives also spoke of their reliance on the support of the MSWs in caring for women and their families, as they relieved them of the less complex visits and thus enabled the midwives to complete their own visits in a timely manner. The midwives also disclosed their appreciation of MSWs in clinics, as they helped clinics run on time, but more importantly they offered emotional support to the midwives. These issues were evidenced in

the thankful comments of the midwives as they recognised that when their spirits flagged under the pressure of work (see Bridget p.84), there was help at hand.

There were also reports of some more serious instances of gatekeeping. There were occasions when the MSWs had so much work that they could not cope and felt powerless to decline work or pass work back to the midwives in fear that they would be seen to be not coping with the work or else incompetent (see Alex p.87 and Hannah p.90). There was also the possibility of backward gatekeeping, as gates are able to open two ways. In one instance, the MSW sought the refuge and reason of her family, and on their advice she approached her midwifery colleagues and found herself a mentor, someone who she felt she could trust, who championed the MSW's cause. This led to an evaluation of the MSW role initiating changes, which effectively impacted on the type of work the MSWs could undertake, as previously outlined.

The findings revealed further the disturbing experience of another MSW, which has been discussed briefly before. The effect of one midwife's gatekeeping practices had a profound effect on the health of the MSW, who provided an account of the extreme exclusionary strategies (Witz, 1992) used by a midwife who became her oppressor and prevented her from working as an MSW whenever they worked alongside each other. As a result of the midwife's oppressive actions, the MSW effectively became redundant in her role. The MSW attempted to justify the midwife's actions in spite of the harm caused to her own health. She suggested one of the reasons for the midwife reacting in the way she did was possibly because she 'felt threatened', and perhaps she was fearful that her role as a midwife was at risk as a result of the MSW role. In the meantime, the team was apparently unaware the situation was so dreadful until the MSW's health deteriorated and forced her to take time off sick. Nevertheless, the MSW decided against putting her health in further jeopardy and found alternative work within the same team of midwives on her return to work. The issues surrounding the circumstances of the MSW's ill health were addressed in a roundabout way, as a problem-solving midwife was moved into the team. The actions of the oppressive midwife could indeed be interpreted in a variety of ways, including safeguarding the realm of the midwife or even championing the role thereof, in which the demonstration of exclusionary strategies may be an acceptable behaviour. However, the extreme actions of the oppressor could simply be interpreted as bullying behaviour (Hadkin & O'Driscoll, 2000).

In support of the midwives' gatekeeping practices, the findings of this study clearly indicated that there were discrepancies in understanding the role and boundaries between themselves and the MSWs, added to which the midwives were less knowledgeable about the skills and competencies of the MSW. Concerns were raised about the MSWs' registration status, and the midwives were uncertain about who remained accountable for the MSWs' actions. The midwives were charged with balancing their professional obligation to delegate safely, which was reflected in the variation and the scope of the work delegated to the MSWs.

Confidence around knowledge

This organising theme was not included in the original aims but emerged as a significant finding for both the MSWs and midwives. Data regarding this theme surfaced as a result of the initial interview question, which was devised to put the practitioners at their ease and encourage them to begin participating in the interview process. The knowledge of the MSW inextricably links their formal education and training with their informal practical learning experiences. These processes equipped them with the consummate knowledge to become MSWs. The findings revealed the conflicting views of the MSWs and the midwives as regards which instilled more confidence in the practitioners and which held more value and worth – formal learning and education or the more informal experiential learning method involving skills and confidence.

MSWs as trained "knowers"

The MSWs appreciated their formal learning and valued the training they had undertaken to attain an NVQ level 2 standard. They understood that this was the minimum requirement of the post, and they were also aware that their training was the basis for further learning in securing a position in the community. Conversely, the midwives were not at all clear and remained unconfident in the content of NVQ training, and neither did they fully understand or appreciate the degree of learning that was required to actually acquire the qualification. Moreover, the midwives were critical of the "in-house" aspect of the training, as it had not taken place in a recognised learning institution such as a college or a university. Overall, they were suspicious of the NVQ process and neither valued its standardisation processes nor respected that it was in fact a nationalised, UK-wide training programme.

MSWs as skilled "doers"

Furthermore, the findings indicated that the midwives placed more worth on the experience and skills the MSWs had amassed whilst working on maternity wards, and they felt assured that their length of experience equated to a practitioner becoming a "knower" and a "doer." The midwives considered the practical experience of a HCA to be more beneficial than their theoretical learning in preparation for their role of MSW in the community. Indeed, midwives who had experience of working in the training team found the more experienced HCAs adapted to the role of MSW and progressed to a stage of distant supervision more quickly than those MSWs with less experience. Both sets of practitioners commented on the number of telephone calls the MSWs made to the midwives. They noticed the number of calls reduced over time, which they associated with the MSW developing increased knowledge, skills and confidence. As a result, the midwives felt more reassured that the MSWs had a heightened awareness of their competencies and boundaries. Moreover, the findings revealed that the MSWs wholly agreed with the midwives, as they too valued their practical experience over and above their theoretical knowledge. This was evidenced as each MSW confirmed their length of

service on the maternity wards, showing their high esteem for their practical experiences. Furthermore, they believed the absence of this experience would have indeed prevented them from working effectively as MSWs.

Clearly, the practitioners placed more worth on the MSWs' practical and experiential learning over and above their theoretical learning. Undoubtedly, the midwives' lack of knowledge and understanding of the NVQ processes influenced their perceptions of the MSWs' theoretical learning, which may possibly have hindered a smoother integration of the MSW role into community practice. Certainly, across the UK there is a lack of consistency around the training and educational requirements of MSWs (Griffiths et al., 2010; RCM 2010), with criticism being aimed at in-house training programmes particularly, as these are deemed less transferrable than formal qualifications (RCM, 2010).

The consequences of confidence

This study began by exploring the working relationships between MSWs and midwives. An analysis of the data identified the issues that held most significance for the practitioners, illustrated by basic and organising themes. The issue that emerged from the data and threaded throughout the themes of the study, and which the MSWs and midwives continued to refer to, either directly or by intimation, was indeed the matter of confidence. As a phenomenon, confidence is considered a subjective matter, as it is not defined or measured easily and is difficult to visualise. Furthermore, there are relatively few studies in nursing and midwifery determining the understanding of the term (Crooks et al, 2005; Bedwell, 2012). The idea of confidence aligns with Bandura's (1986) model of self-efficacy, rooted in social cognitive theory. Bandura (1986) believed we are our own agents of change and can make things happen, in that 'what people think, believe, and feel affects how they behave' (Bandura, 1986, p. 25). Bedwell (2012) considers confidence to be balanced between cognition and aspects of knowledge, experience and emotion, facets relating to this study.

The confidence of the MSWs and midwives grew as a result of their developing relationships and interactions in everyday practice, as they negotiated their roles and defined their boundaries. Their confidence was further strengthened as the MSWs and midwives first learned about and came to understand the features and jurisdictional working of the role. Indeed, it appeared the more midwives experienced working alongside the MSWs, the more their confidence around the MSW role increased, thus aligning with Stewart et al.'s (2000) study which reported experience to be a key factor in developing confidence. A co-founding factor that assisted in the production of confidence was recognising and comprehending how the MSWs accrued their knowledge by means of their formal education and informal training. Another of the key factors that affected the development of confidence was the midwives understanding the competencies of the MSWs, and in point of fact, not knowing or misunderstanding the MSWs' capabilities was where some of the challenges lay for the midwives. It was in the presence of these challenges when the midwives were under-confident, as a

result of either being unsure of their duties of delegation or that they may be eroding their own role, that they instigated gatekeeping practices in an attempt to feel secure and safeguard their role. There appeared to be a correlation between the issues of gatekeeping and confidence whereby the midwives relinquished control of work, once considered to be the realm of the midwife, as their confidence increased in the MSW role. This was in response to understanding the role and its limitations, which had been established through the negotiation of their jurisdictional working. On the whole, and through the interactions of the practitioners, working relationships began to form and started to improve as the midwives became more confident in the art of delegation and realised the MSW was indeed an assistant role. Another factor that influenced the practitioners' confidence was the element of trust. There appeared to be a reciprocal relationship between confidence and trust intimated by the MSWs and midwives, both generated as a result of their interactions as they developed their working relationships.

Conversely, some relationships remained dormant or nonexistent in the absence of any interaction. In these instances, once the relationships had been kick-started, they too seemed to progress along similar pathways in the creation of trust and confidence. There were also occasions where in the process of negotiating the roles, the roles blended and the boundaries became blurred. As there were no instructions to guide either practitioner, they called into account their own judgement and confidence regarding their role in assisting with decisions around their boundaries.

However, one relationship did not grow or develop, as the interactions between the practitioners involved were extremely poor. Confidence and trust in this relationship never formed or established and the gatekeeping practices of the midwife became oppressive. This particular relationship is noteworthy, although it needs to be seen in perspective against the other relationships that formed.

Parallels: medical men and midwives

In Chapter Two I provided an account of the history of how midwives established their professional status. Through the last few centuries midwives and their professional status have been challenged by patriarchal agencies including the Church, the state and medical men (Donnison, 1977). In the latter years a power struggle has continued between midwives and the medical men over the jurisdiction of women's pregnancy and birth experiences. Previously, medical men had gained their professional status by virtue of their educational qualifications, recognised by universities and the state, both of which are considered powerful political adversaries and patriarchal establishments. In contrast, midwives had only their empirical knowledge to draw upon and the support of the women to whom they provided a cost-effective service up until the profession of the midwife became statute following the Midwives Act of 1902. Similarities can be drawn to this study, whereby the midwives appear to be repeating a similar behaviour towards the MSWs as those exhibited by medical men to midwives over a century ago. At the time, midwives experienced subjugation at the hands of the medical men, and now it appears that midwives have become the oppressors instead. Another

similarity that can be drawn concerns the ratio of medical men to pregnant women dictated that they were unable to provide a service to all women and therefore became reliant upon the midwives for the provision of a more comprehensive midwifery service as they were more numerous. This latter-day scenario draws parallels with today's midwifery services in the UK, as apparently there is a national shortage of trained and registered midwives (Kirkham et al., 2006) to maintain current or provide future midwifery provision for women. As a consequence, maternity services have responded by employing MSWs (NHS Employers, 2006).

Parallels: registered nurses and enrolled nurses

A second parallel concerns the issue of enrolled nurses and the MSW role. In Chapter Two I discussed the introduction of the secondary level of nursing, i.e. the assistant enrolled nurse. Here again a role was introduced in response to a shortage of trained staff towards the end of the Second World War, and once again this was an assistant role. There is some resemblance to the MSW role, as both are assistant roles and both required a much shorter training route. Other similarities include that the secondary level nurse remained unregistered for 15 years (Kessler et al., 2012). At the present time, the MSW role is actually unregistered and unregulated, a phenomenon that continues to be a highly debated issue (Hey, 2008; NMC, 2010; RCM, 2010; NHS Employers, 2011) within existing NHS services. The NHS has observed and experienced the decline and removal of the enrolled nurse whilst modernising the NHS, and effectively given way to the employment of a plethora of support workers, arguably replacing one assistant nurse for another except for its name change and lack of status.

Parallels: midwives and volunteer peer supporters

A third analogy that correlates with the experiences of the MSWs in this study revolves around the experiences of volunteer peer supporters (DH, 2000). In their introduction to maternity services they too were viewed with suspicion (Hoddinott et al., 2006; Curtis et al., 2007), again in regard to their educational statuses, but also the potential erosion and replacement of the midwife's role. It was only through shrewd negotiations and the sheer determination of the women involved that they have continued and become an integrated feature of service provision in the community (Dyson et al., 2006; NICE, 2008b). The MSWs experienced similar difficulties to volunteer peer supporters in gaining access to pregnant women and their families to provide care, and the gatekeepers in these shared experiences were indeed midwives (Curtis et al., 2007) who "allowed" or "gave permission" to the workers to provide services. As previously discussed, the actions of the midwives in this study may be interpreted as defending the sphere of the midwife and their professional status and controlling their "power" over these gatekeeping mechanisms and exclusionary strategies. However, differences between MSWs and volunteer peer supporters in community maternity services, other than their role descriptions, are in fact that MSWs are in paid NHS employment whilst the majority of peer supporters are not and remain voluntary.

It seemed appropriate to use these parallels between the experiences of midwives, enrolled nurses and volunteer peer supporters, as they had all been subjected to the subjugation practices of professionals. The experiences of the MSWs as they attempted to define an area of practice for themselves were indeed comparable with these historical scenarios, as they too had been exposed to professional exclusionary practices.

Conclusion to Chapter Five

As a result of this study a picture has emerged that illustrates how relationships were constructed between the MSWs and the midwives, a picture interwoven with the negotiation of their roles and boundaries. The findings revealed the difficulties the practitioners encountered when a new practitioner role was introduced into an established service. Furthermore, the findings indicated that the attitudes and actions of the practitioners influenced the development of their working relationships. Resultantly, the nature of these relationships impacted on the scope of work the MSWs were "permitted" to undertake, thereby enabling the midwives to retain power and control over the jurisdiction of the MSW role, although the midwives did provide a number of justifications for these gatekeeping and exclusionary practices. The findings indicated that the midwives exhibited these exclusionary traits whenever they appeared vulnerable and/or in areas where they lacked clarity, for example around roles and boundaries, accountability, jurisdiction or the threat of partial or complete displacement of their role by the MSW. Clearly, the midwives had a poor understanding of what defines an occupational status and how it is different to that of a professional one.

Contrastingly, the findings also revealed some excellent collaborative working between some of the practitioners, but only once they had assuaged their suspicions after a period of working together. The study found that it took time for these relationships to develop to a level of reciprocity around each other's roles and where there was increased appreciation and value placed on their partnership working. In context it would appear that a period of time needs to be allowed to adjust to new ways of working, particularly if people are involved in the changes. Clearly, the findings indicated that the individuals involved were responsible for implementing these changes and therefore required appropriate information and support to ensure a consistent level of service provision and the safeguarding of individuals.

In writing this chapter I found that whilst the organising themes seemed ordered and separate, the basic themes were interlinked and overlapped one another. At times I am seen to repeat the various basic themes and they seem to be threaded throughout this chapter. In the next chapter I summarise the overall findings of this study and consider the implications for practice policy, education and research. I also examine the study's strengths and limitations, and I conclude the study by reflecting on my journey through the research process.

CHAPTER SIX

Summary, Conclusion and Recommendations

This chapter draws together the salient points of this study and presents the main conclusions. I have included a discussion of the study's strengths and limitations and consider whether I would do anything differently if ever I were to undertake a similar study. I address the implications for clinical practice and policy, education and further research, and I provide recommendations for practice and further research. This study has enabled me to understand and appreciate some of the complexities of introducing change into established community midwifery practice, and I have chosen to include an abridged account of my research journey, which concludes the study.

In summary

The aims of this study were to explore the working relationships between MSWs and midwives and included examining their roles and boundaries. Overall, the aims of this study were achieved by listening to the voices of the MSWs and midwives who provided insights into their roles, and determining how these impacted on their working relationships. The overarching theme that emerged from the data was the matter of confidence. The study highlighted issues that instilled or undermined confidence in the relationships between the practitioners, associated with their negotiating their roles and boundaries. Furthermore, it revealed the different ways in which the MSW role was perceived by the midwives. Integrating MSWs into community practice proved both challenging and beneficial for all the practitioners involved, affecting not only practice but also the care of women, mothers and their families. The practitioners' experiences had been hidden from view, as seemingly the MSWs had "fitted in" to the system and conformed to the social norms of organisational working. The practitioners had never been able to verbalise overtly their anxieties and worries until this study happened to materialise. The study enabled them to take their concerns out of the private sphere and place them into the public domain, in the interests of improving the roles and working relationships between those involved in the integration of new roles into existing practice. Providing support, information and guidance to the practitioners in times of change may help overcome some of the issues highlighted in this study and make for a smoother integration of MSWs into midwifery practice.

Limitations

One of my initial concerns was about keeping the study simple and straightforward, as I recognised myself as a novice researcher. Therefore, I chose an area of practice that on the surface seemed uncomplicated. However, this proved not to be the case, as it called upon people's thoughts,

perceptions and feelings, i.e. complicated matters of life sometimes, with no definitive answers or conclusions. At times I felt out of my depth, sometimes because of the complicated issues, others because I felt directionless as a result of my naivety regarding research processes. Rubin & Rubin (1995) suggest that researchers should consider the intensive nature of undertaking qualitative research – a phenomenon I did not truly appreciate until I embarked upon this study. Similar to the LREC, I was concerned about the small number of participants involved in the study. As it transpired, our concerns were unfounded, as the interviews generated copious amounts of data, and I believe a larger study involving more people would have been impractical for a novice researcher like me. Another area of disquiet was around the interviews used to gather the data, which may potentially have limited the participants' responses to the questions asked. In fact, their replies went beyond these questions, evidenced by the rich detail captured in their accounts. The sensitive nature of the study and the willingness of the MSWs and midwives to disclose their personal working experiences were other sources of concern, as potentially the MSWs and midwives disclosures may have been interpreted as whistleblowing. However, they gladly responded by providing insights into their roles, relationships and lived experiences.

Moreover, I was anxious of me as the researcher and considered that my insider status as a midwife and a colleague (further information regarding insider/outsider status can be found in Chapter Three) could perhaps have limited the responses of the MSWs and midwives, although there was research evidence to countenance such anxieties, which included the notion that inside researchers can build early rapport (Watts, 2006; Simmons 2007), but there is also the added benefit of an inside researcher understanding the culture and language of the researched (Gerrish, 2007; Burns et al., 2010). As it happened, the majority of the participants chose to disclose their personal thoughts and experiences. Only one MSW was hesitant in revealing her experiences, but even then she chose to share them towards the end of her interview when the recorder had been turned off, the use of which she permitted for the purpose of the study. At the time it made me re-evaluate my data collection method, its appropriateness and the choice of researcher. I concluded that neither needed to change. The method had so far successfully captured data rich in detail, and whilst a different researcher may have potentially gathered similar or more or less detailed data than I had myself, there was in fact no other researcher available to undertake the study.

Strengths

I considered one of the strengths of this study lay in its approach. I chose to undertake a qualitative approach, framed within a feminist perspective, which unearthed an abundance of data rich in description and detail, phenomena that may not have been achieved by any other method. I also regarded the sampling methods I used to be another of the study's strengths. The use of purposive and snowball sampling led to the selection of participants who provided the data upon which the study was dependent. By far the greatest strength lay with the participants and their motivation to discuss and disclose intimate and sensitive details about their roles, boundaries and working relationships

with their colleagues, and to share the difficulties and challenges they faced when integrating the role of the MSW, either as an MSW or as a midwife. The MSWs and midwives were the strength this study was built upon, because without them it would never have happened.

Implications for practice

The literature review (Chapter Two) highlights what makes a profession a profession and a professional a professional by outlining the different theories of how professions and professionals are constructed. The findings revealed there was a lack of knowledge regarding the differences between occupational and professional status, which in turn created difficulties in defining roles and subsequently impacted on the relationships between the MSWs and the midwives. Practitioners need to know their own roles and limitations and be provided with knowledge about other different roles and their limitations, so that clear boundaries may be defined to ensure safe, consistent and harmonious working. Furthermore, they need to mutually respect each other's acquired knowledge, but in order to do so they need to understand the training processes that have been required to attain such knowledge. This is particularly so for midwives regarding MSW training and education. In addition, practitioners need to be encouraged to realise how professions have emerged, and then recognise the struggles from whence midwifery came and recognise the exclusionary strategies used by their oppressors in the subjugation of midwives. In doing so, practitioners are encouraged not to rewrite history and become neither the oppressor nor the oppressed, but instead be supportive of and sensitive to others in times of change.

Implications for policy

The findings revealed a number of missed opportunities to inform and report change to practitioners about modifications to their practice. The employing organisation needs to look to its culture, defined by the people working within the organisation who provide consistency and order (Muller-Smith, 1997), for success and survival in the long term when instigating changes. Therefore, to assist practitioners in surviving new changes in today's workplace, effective communication is paramount. A duty of care lies with this same organisation to ensure that practitioners are equipped with adequate knowledge and skills for them to continue working effectively in their practices. This implies that workers need to learn and be taught to problem solve as groups or in teams, with the purpose of implementing change. Support and evaluation of services also need to be carried out, not only for service users but also for service providers to realise the effects of any new and/or implemented changes and to inform new practice and policy.

Implications for education

Student midwives are taught to reflect on their practice and to use their reflections as learning events, while midwives are encouraged to do the same and evaluate what they have learnt through this

process. We do this as individuals, but what we have yet to learn is the art of collaboration, particularly when problem solving – something which we have not been taught to do either in our formative school years or within our places of work. We have not been encouraged to do so, as principally, when it came to passing exams or gaining accreditation, it was classed as "cheating" (Muller-Smith, 1997). Problem solving within groups or teams needs to be part of learning and practice for practitioners, as most are commonly employed by organisations which initiate change on a regular basis. Undoubtedly, acquiring these types of skills would benefit individuals and the organisation, should groups or teams be able to manage such changes. It is suggested that these educational messages are delivered in a creative, thought-provoking and meaningful way so that they may be remembered. This may be through interactive workshops or theatre workshops that can involve the participation of the audience.

Implications for research

This study researched people and their thoughts, perceptions and feelings about roles, boundaries and relationships. I found that when seeking studies concerning relational working, particularly in regard to working relationships, it was an understudied or rather and under-reported subject. This implies there are possibly areas of relational working in midwifery that remain undiscovered for researchers to seek out, identify and explore.

Recommendations for practice

- It is recommended that practitioners directly involved in practice changes need to be supported. Appropriate support would include providing opportunities to exchange communication before, during and after the change occurs. This can be offered on an individual or a group basis. Other means of communication need to be considered in the form of texts, e-mails, memos, letters and informational literature to update and inform the agents of change. Mentor support needs to be considered for practitioners entering a new role whilst adjusting and consolidating learning.

- It is recommended that practitioners need to be provided with their own role description and responsibilities and to know their roles and recognise their limitations. When working alongside other practitioners to whom they are required to delegate work, the delegator needs to know the principles of delegation and be assured that the practitioner to whom they are delegating is able to undertake the work proficiently. Therefore, the delegator needs to understand and be familiar with the practitioner role and the practitioner's limitations, which requires access to the role description and responsibilities.

Recommendations for further research

- It is recommended that this research study is repeated on a larger scale, as the present research study is limited not only by its small numbers but also its relation to one town in the north of England.
- It is recommended that a follow-up research study is planned, to research the same place and participants to reveal any new changes.
- It is recommended that a research study's remit is widened to include the impact on maternity service users and their perceptions of the roles and relationships between MSWs and midwives, in order to ensure maternity services meet the needs of their users.

Reflections on my Research Journey

I have reached the end of my journey of writing up my study, but I have come to realise my learning is only just the beginning of research and research matters. In rewriting and re-editing the changes required by my assessors, I feel I have established ways of thinking and writing like a researcher. The journey has been so very, very long – starting with the inkling of an idea for a research project way back in 2005, and it has left me feeling exhausted.

In reading the journey of others, it seems they liken their journey to a huge learning curve. I instead feel like I have been on one of those wavy slides, journeying to the top on foot and feeling exhausted and then beginning my slide down over the bumps, sometimes changing lanes and having to correct my journey to get back in the right lane again and continue downwards.

At the beginning I felt I had lots of enthusiasm and motivation to accomplish this study but I was clearly directionless in which way I needed to go, as I had only my limited experience to draw upon. My supervisors made suggestions and I followed. I noted in my journal when I was challenged by one of my supervisors about how I intended to direct the study, and I recall my reactions and replies. It was at this point that I recognised myself taking charge of my study. Later, I would be challenged by another of my supervisors as to how could I use a modified grounded theory approach and frame it in a feminist perspective. At the time I did not see any conflict, although now I understand a little better thanks to my assessors.

The revelations of the study at times were distressing for me, let alone the practitioners who disclosed the harrowing details of their experience. There were also exquisite moments of humour and joy that made me laugh and rejoice that the MSW/midwife relationships were indeed 'fab'. Furthermore, I had previously recognised these practitioners as friends and colleagues, but now I needed to approach them as research participants in my study, something I found rather onerous.

My motivation dipped at times and I thought this study may never come to fruition and I felt very low. However, I knew I needed to give the midwifery support workers and the midwives their voices in the form of this study, which could have so easily lain in a dusty cupboard. Their voices saw me through and I will be forever indebted to them for allowing me to record their thoughts and experiences.

I'm sure my supervisors have felt frustrated with me at times for my lack of progress, and I acknowledge I have been slow to learn and slow to write, but they have nevertheless continued to support me in my study – and I am thankful for their patience and support.

To conclude, I have learnt many things about research along my journey. I have already spoken of how I have developed my writing skills, but I have also developed my reflecting and critical thinking skills. I have practiced my interviewing skills and learnt to deal with sensitive issues whilst continuing to be "the researcher." That is not to say that I was not affected by the stories that unfolded. I am able to recognise my commitment to this study remained supreme, because the issues I was researching were poignant to me as a midwife and woman. I have maintained my integrity by staying truthful and honest to the voices of the midwifery support workers and midwives, and to this end I end this part of the research.

References

Abbott, A. (1988) *The system of professions: an essay on the division of expert labour*. Chicago: University of Chicago Press.

Abbott, P., Meerabeau, L. (1998) *Sociology of the caring professions.* 2nd edn. London: UCL Press Ltd.

Abbott, A., Wallace, C., eds. (1990) *The sociology of the caring professions.* Basingstoke: Falmer Press.

Alcoff, L.M. (1998) *Epistemology: the big questions.* London, England: Blackwell.

Altheide, D.L., Johnson, J.M. (1994) Criteria for assessing interpretive validity in qualitative research. *In:* Denzin N.K., Lincoln, Y.S., eds. *Handbook for qualitative research,* 2nd edn. Newbury Park, CA: Sage.

Anderson, G., Arsenault, N. (2001) *Fundamentals of educational research.* 2nd edn. London: Routledge Falmer.

Aroni, R., Goeman, D., Stewart, K., Sawyer, S., Abramson, M., Thein, F. (1999) *Concepts of rigour: when methodological, clinical and ethical issues intersect*. Vol. 2000. AQR. Available from: [http://www.aqr.org.au/local/offer/papers/RAroni.html] Accessed 01/11/13.

Bach, S., Kessler, I., Heron, P. (2008) Role redesign in a modernised NHS: the case of healthcare assistants. *Human Resource Management Journal.* 18(2): 171–187.

Bandura, A. (1986). *Social foundations of thought and action: a social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.

Barrett, M. (1987) Women's oppression today. 2nd edn. London Verso.

Bate, P., Bevan, H., Robert, G. (2004) Towards a million change agents. a review of the social movements literature: implications for large scale change in the NHS. *NHS Modernisation Agency,* 55.

Becker, H.S. (1970) *Sociological work.* Chicago: Aldine Press.

Becker, H.S., Greer, B., Hughes, E.C., Strauss, A.L. (1961) *Boys in white.* 11th print 2009. Chicago: University of Chicago press.

Bedwell, C. (2012) *An analysis of the meaning of confidence in midwives undertaking intrapartum care.* Unpublished PhD Thesis. University of Manchester.

Behar, R. (1996) *The vulnerable observer: anthropology that breaks your heart.* Boston: Beacon Press. *Cited in:* Bochner, A.P. (2001) Narrative's virtues. Q*ualitative Inquiry.* 7(2): 131-156.

Belenky, M.F., Tarule, J.M., Goldberger, N.R., McVicker-Clinchy, B. (1986) *Women's ways of knowing.* New York: Basic Books.

Bochner. A. (2000) Criteria against ourselves. *Qualitative Inquiry.* 6: 383-396.

Bochner, A. (2001) Narrative's virtues. *Qualitative Inquiry. 7: 131-157.*

Bolak, H.C. (1996) Studying one's own in the middle east: negotiating gender and self other dynamics in the field. *Qualitative Sociology.* 19(1).107-130.

Bolling, K., Grant, C., Hamlyn, B., Thornton (2007) A. *Infant Feeding Survey 2005.* London: The Information Centre, Government Statistical Service, UK Health Departments.

Bosley, S., and Dale, J. (2008) Healthcare assistants in general practice. *British Journal of General Practice.* 1: 58(547): 118–124.

Bradbury-Jones, C., Alcock, J. (2010) Nursing students as research participants: a framework for practice. *Nurse Education Today.* 30: 192-196.

Brennan, G., McSherry, R. (2007) Exploring the transition and professional socialisation from health care assistant to student nurse. *Nurse Education Practice.* 7(4): 206-214.

Briggs, A. (1972) *Report of the committee on nursing.* London: HMSO.

Brown, L.M., Debold, E., Tappan, M.B., Gilligan, C. (1991) Reading narratives of conflict and choice for self and moral voices. a relational method. *In:* William, M., Gewirtz, J.L. eds*. Moral behaviour and development. Volume 2 Research.* Hillsdale, NJ: Lawrence Erlbaum.

Brown, L. M., Gilligan, C. (1992) *Meeting at the crossroads: women's psychology and girls' development.* Cambridge, MA: Harvard University Press.

Bryman, A. (1988) *Quality and quantity in social research.* London: Unwin Hyman.

Bulbeck, C. (1998) *Re-orienting western feminisms.* Cambridge: Cambridge University Press.

Bullough, V.L. (1974) *The subordinate sex.* Urbana: University of Illinois Press.

Burkhardt, M., Nataniel, A. (2002) *Ethics and issues in contemporary nursing.* Clifton Park, NY: Thompson Learning inc.

Burns, E., Fenwick, J., Scmied, V., Sheehan (2010) A. Reflexivity in midwifery research: the insider/outsider debate.*Midwifery.*28(1):52-60

Carolan, M. (2003) Reflexivity a personal journey through data collection. *Nurse Researcher.* 10(3): 7-14.

Cluett, E.R., Bluff, R. (2000) *Principles and practice of research in midwifery.* London: Balliere Tindall.

Code, L. (1991) *What can she know? Feminist theory and the construction of knowledge.* Ithaca, NY: Cornell University Press.

Collins, P. (1998) Negotiating selves: reflections on unstructured interviewing. *Sociological Research Online* 3.34 Available from: [http://www.socresonline.org.uk/3/3/2.html] Accessed 01/11/13.

Cook, J.A. Fonow, M.M. (1986) Knowledge and Women's Interests: Issues of Epistemology and Methodology in Feminist Sociological Research. *Sociological Inquiry.* 56(1): 2-29.

Cook, J.A. Fonow, M.M. (1990) Knowledge and women's interests; issues of epistemology and methodology in feminist sociological research. *In:* McCarl Mielsen, J. ed.) *Feminist research methods; exemplary reading in the social sciences.* Boulder, CO: Westview.

Corbin, J., Strauss, A. (2008) *Basics of qualitative research.* Thousand Oaks, CA: Sage.

Cowell, B., Wainwright, D. (1981) *Behind the blue door: the history of the royal college of midwives 1918-1981.* Balliere Tindall: London.

Cox, C. (2010) Legal responsibility and accountability. *Nursing Management.* 17(3): 18-20.

Crompton, R. (1987) Gender status and professionalism. *Sociology.* 21: 413-428.

Crooks, D., Carpio, B., Brown, B., Black, M., O'Mara, L., Noesgaard, C. (2005) Development of professional confidence by post diploma baccalaureate nursing students. *Nurse Education in Practice*. 5: 360-7.

Crozier, K. MacDonald, S. (2009) Innovation and research in midwifery. *Midwives.* 1: 26.

Curtis, P., Ball, L., Kirkham, M. (2006) Why do midwives leave? (not) being the kind of midwife you want to be. *Journal of British Midwifery.* 14(1): 27-31.

Curtis, P., Woodhill, R., Stapleton, H. (2007) The peer-professional interface in a community-based breast feeding peer-support project. *Midwifery* 23: 146-156.

Denzin, N.K., Lincoln, Y.S. eds. (1998) *Strategies of qualitative inquiry.* 2nd edn. Thousand Oaks, CA: Sage.

Department of Health (1993) *Changing childbirth: report of the expert maternity group (Cumberlege report).* London: HMSO.

Department of Health (2000) *Making a difference: strengthening the nursing, midwifery and health visiting contribution to health care.* London: HMSO.

Department of Health (2004) *National service framework for children, young people and maternity services: maternity standard 11.* London: HMSO.

Department of Health (2006) *Our health, our care, our say: a new direction for community services.* London: The Stationery Office.

Department of Health (2007) *Maternity matters: choice, access and continuity of care in a safe service.* London: Department of Health.

Dickson-Swift, V., James, E., Kippen, S., Liamputtong Rice, P. (2006) Blurring boundaries in qualitative health research on sensitive topics. *Qualitative Health Research.* 16(6): 853-871.

Dietrich, M., Roberts, J. (1997) Beyond the economics of professionalism. *In:* Broadbent, J., Dietrich, M., Roberts, J. eds. *The end of the professions?* Routledge: London.

Donahue, M.P. (1996) *Nursing: the finest art.* St Louis, MO: Mosby.

Donnison, J. (1977) *Midwives and medical men.* London: Heinemann.

Drevdahl, D. (1999) Sailing beyond: nursing theory and the person. *Advances in Nursing Science.* 21(4): 1-13.

DuBois, E. (1985) Feminist scholarship; kindling in the groves of academe. University of Illinois Press: Urbana.

Duffy, K., Ferguson, C., Watson, H. (2002) Data collecting in grounded theory - some practical issues. *Nurse Researcher.* 11(4): 67-78.

Durkheim, E (1958) Rules of the sociological method. New York: The Free Press. *In:* Macdonald, K.M. (1995) *The sociology of the professions.* London: Sage.

Dyson, L., Renfrew, M., McFaden, A., McCormick, F., Herbert, G., Thomas, J. (2006) *Promotion of breastfeeding initiation and duration. Evidence into practice briefing.* London: NICE

Edwards, R. (1990) Connecting method and epistemology: a white woman interviewing black women. *Women's Studies International Forum.* 13: 477-490.

Elliot. P.R.C. (1972) *Sociology of the professions.* London: MacMillan.

Ellis, C. (1991) Sociological introspection and emotional experience. *Symbolic Interaction,* 14: 23-50.

Ellis, C. (2007) Telling secrets, revealing lives: relational ethics in research with intimate others. *Qualitative Inquiry*. 13: 3-29.

Etzioni, A. (1969) *The semi-professions and their organisation: teachers, nurses and social workers.* New York: Free Press.

Fielding, N. (1994) Varieties of research interviews. *Nurse Researcher.* 1(3): 4-11.

Finch, J. (1984) It's great to have someone to talk to: the ethics and politics of interviewing women. *In*: Bell, C., Roberts, H. eds. *Social researching: policies, problems, and practice*. London: Routledge and Kegan Paul.

Flick, U. (2009) *An introduction to qualitative research.* 4th edn. London: Sage.

Finlay, L. (2006) 'Rigour', 'ethical integrity' or 'artistry'? reflexively reviewing criteria for evaluating qualitative research. *British Journal of Occupational Therapy.* 69(7): 319-326.

Finlay, L., Gough, B. Eds. (2003) *Reflexivity: a practical guide for researchers in health and social sciences.* Oxford: Blackwell publishing.

Fog, J. (2004) *Med samtalen som udgangspunkt* [With the conversation as basis]. Copenhagen: Akademisk Forlag. *Cited in:* Kvale, S. (2007) *Doing interviews.* London: Sage.

Fonow, M.M., Cook, J.A. eds. (1991) *Beyond methodology: feminist scholarship as lived research.* Bloomington: Indiana University Press.

French, V. (1986) Midwives and maternity care in the Roman world*. Helios, New Series*, 12 (2): 69-84. Available at: [http://www.indiana.edu/~ancmed/midwife.HTM] accessed 01/11/13.

Freidson, E. (1970) *Professional dominance: the social structure of medical care*. New York: Atherton Press.

Friedson, E. (1983) The theory of the professions the state of the art. *In:* Dingwell, R., Lewis, P. eds. *The sociology of the professions.* London: Macmillan.

Gerrish, K. (1997) Being a ''marginal native'': dilemmas of the participant observer. *Nurse Researcher* 5: 25–34.

Gilligan, C. (1982) *In a different voice: psychological theory and women's development.* Cambridge: Harvard University Press.

Glaser, B.G., Strauss, A.L. (1967) *The discovery of grounded theory: strategies for qualitative research.* Illinois: Aldine.

Goldberg, S. (1973) *The inevitability of patriarchy*. William Morrow: New York.

Goode, W.J. (1957) Community with a community: the professions. *American Sociological Review.* 22: 194-200.

Green, J., Thorogood, N. (2004) *Qualitative methods for health research.* London: Sage.

Green, M. (2009) The sources of eucharis in Rosslin's rose garden for pregnant women and midwives. Available at: [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2668903/pdf/medhis5302-01-167.pdf] accessed 01/11/13.

Grielsammer, M. (1991) The midwife the priest and the physician: the subjugation of midwives in the low countries at the end of the middle ages. *Journal of Medieval and Renaissance Studies.* 21(2): 285-385.

Griffin, R., Blunt, C., Dunkley-Bent, J. (2011) *The impact of maternity care support workers in NHS Scotland.* Edinburgh: NES

Griffiths, P., Robinson, S. (2010) *Moving forward with healthcare support workforce regulation.* London: National Nursing Research Unit.

Hadkin, R., O'Driscoll, M. (2000) *The bullying culture: cause, effect and harm reduction.* London: Books for Midwives.

Haig, B.D. (1997) Feminist research methodology. *In:* Keeves, J.P. ed. *Educational research methodology and measurement. an international handbook.* Oxford: Elsevier.

Hall, J., Stevens, P. (1991) Rigour in feminist research. *Advances in Nursing Science.* 13(3): 16-29.

Hammersley, M., Gomm, R. (1997) Bias in social research. *Sociologicalresearchonline.* 2(1): Available at: [http://www.socresonline.org.uk/2/1/2.html   Date: 1998-11-17] Accessed 01/11/13.

Hansen, E.C. (2006) *Successful qualitative health research. a practical introduction.* Berkshire, England: Open University Press.

Haraway, D. (1991) *Simians, cyborgs and women: the reinvention of nature.* New York: Routledge.

Haraway, D. (1997) *Modest_witness @second millennium. Femaleman©_meets_oncomouse™:feminism and technoscience.* New York and London: Routledge.

Harding, S. ed. (1987) *Feminism and methodology.* Milton Keynes: Open University Press.

Harding, S. (1993) Rethinking standpoint epistemologies: what is strong objectivity? *In:* Alcoff, L. Potter, E. *Feminist epistemologies.* London, England: Routledge.

Hatt, S. (1997) *Gender, work and labour markets.* Basingstoke: Macmillan Press

Hawkesworth, M. (1989) Knowers, knowing, known: feminist theory and claims to truth. *Signs: Journal of Women in Culture and Society.* 14: 533-547.

Hearn, J. (1982) Notes on patriarchy, professionalisation and the semi-professional. *Sociology.* 16(2): 184-202.

Hesse-Biber, S. (2012) *Handbook of feminist research theory and practice.* 2nd edn. Thousand Oaks, CA: Sage.

Hesse-Biber, S., Leavy, P.L. (2007) *Feminist research practice; a primer.* Thousand Oaks: Sage.

Hesse-Biber, S., Leckenby, D. (2004) How feminists practice social research. *In:* Hesse-Biber, S., Yaiser, M.L. eds. *Feminist perspectives on social research.* New York: Oxford University Press.

Hey, M. (2008) *Maternity support workers; help or hinder?* Report Prepared for Yorkshire and Humber hospitals.

Hobbes, T. *In:* Clark, A. ed. (2010) *Brief lives' v1 a-h: chiefly of contemporaries set down by John Aubrey, between the years 1669-1696 (1898).* Whitefish, MT: Kessinger Publishing.

Hoddinott, P., Chamlers, M., Pill, R. (2006) One to one or group based support for breastfeeding? Women's perceptions of a breastfeeding peer coach intervention birth. *Birth.* 33(2):139-146.

Hoffman, J. (2001) *Gender and sovereignty; feminism the state and international relations.* Hampshire: Palgrave Macmillan.

Holloway, I., Wheeler, S. (1996) *Qualitative research for nurses.* Oxford: Blackwell Science.

Hughes, E.C. (1958) *Men and their work.* New York: Free Press.

Hughes, E.C. (1963) Professions. *Daedalus*, 92: 655-68.

Hugman, R. (1991) *Power in caring professions.* London: Macmillan.

Jagger, A. (1983) *Feminist politics and human nature.* Lanham, MD: Rowman and Littlefield.

Johnson, M. (1978) Big fleas have little fleas-nurse professionalism and nursing auxiliaries. *In:* Hardie, M., Hockey, L. eds. *Nursing auxiliaries in health.* London: Croom Helm.

Johnson, T.J. (1972) *Professions and power*. London: Macmillan.

Kanuha, B.K. (2000) "Being" native versus "going native": conducting social work research as an insider. *Social Work.* 45(5): 439-447.

Keddy, B. (1992) The coming of age of feminist research in Canadian nursing. *The Canadian Journal of Nursing Research.* 24(4): 5-10.

Kemp, S., Squires, J. (1997) *Feminisms.* Oxford: Oxford University Press.

Kent, J. (2000) *Social perspectives on pregnancy and childbirth for midwives, nurses and the caring profession.* Buckingham: Open University Press.

Kessler, I., Bach, S., Heron, P. (2007) Comparing assistants in education and social care. *International Journal of Human Resource Management.* 18 (9): 1648-1665.

Kessler, I., Heron, P., Dopson, S. (2012) *The modernisation of the nursing workforce.* Oxford: Oxford University Press.

Kingdon, C. (2005) Reflexivity: not just a qualitative methodological research tool. *British Journal of Midwifery.* 13(10): 622–7.

Kingdon, C. (2009) *Sociology for midwives.* London: Quay Books.

King, K.E. (1994) Method and methodology in feminist research: what is the difference? *Journal of Advanced Nursing.* 20: 19-22.

Kirkham, M., Morgan, R.K., Davies, C. (2006) Why do midwives stay? *Department of Health and Bedfordshire and Hertfordshire Workforce Development Confederation.* Women's Informed Childbearing and Health Research Group: University of Sheffield.

Kralik, D., van Loon, A.M. (2008) Feminist research. *In:* Watson, R. McKenna, H. eds. *Nursing research-designs and methods.* PA, USA: Churchill Livingstone.

Kreckel, R. (1980) Unequal opportunities structure and labour segmentation. *Sociology.* 4: 525–50.

Krizek, R.L. (2003) Ethnography as the excavation of personal narrative. *In:* Clair, R.P. ed. *Expressions of ethnography: novel approaches to qualitative methods.* New York: State University of New York.

Kvale, S. (2007) *Doing interviews.* London: Sage.

Larson, M.S. (1977) *The rise of professionalism. A sociological analysis.* London: University of California Press.

Leap, N., Hunter, B. (1993) *The midwife's tale: an oral history from handywoman to professional midwife,* London: Scarlett Press.

Leninger, M.M. (1994) Evaluation criteria and critique of qualitative research studies. *In:* Morse, J. ed. *Critical issues in qualitative research methods.* London: Sage.

Letherby, G. (2003) *Feminist research in theory and practice.* Buckingham, England: Open University Press.

Lewis, G. ed. (2007) The Confidential Enquiry into Child and Mother *Health CEMACH: Saving Lives – reviewing maternal deaths to make motherhood safer. The seventh report on confidential enquiries into maternal deaths in the United Kingdom 2003-2005.* London: CEMACH

Lincoln, Y.S. (1995) Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry.* 3: 275–289.

Lincoln, Y.S., Guba, E.G. (1985) *Naturalistic enquiry.* Beverley Hills CA: Sage

Lindsay, P. (2004) Introduction of maternity care assistants. *British Journal of Midwifery.*12 (10): 650-659

Long, T., Johnson, M. eds. (2006) *Research ethics in the real world: issues and solutions for health and social care.* London: Churchill Livingstone, Elsevier.

Longino, H. (1990) Science in social knowledge as: values and objectivity in scientific inquiry. Princeton, NJ: Princeton University Press.

Longino, H. (1997) Feminist epistemology as a local epistemology. *Aristotelian Society.* 17: 19-35.

Macdonald, K.M. (1995) *The sociology of the professions.* London: Sage.

Maguire, M. (1996) Considering more feminist participatory research: what's congruency got to do with it? *Qualitative Inquiry.* 2(1): 106-118.

Marshall, C., Rossman, G.B. (2010). *Designing qualitative research.* 5th edn. California: Sage Publications.

Mason, J. (2002) *Qualitative researching.* 2nd edn. London: Sage.

Mauthner, M., Birch, M., Jessop, J., Miller, T. eds. (2002) *Ethics in qualitative research.* Thousand Oaks, CA: Sage.

Mauthner, N., Doucet, A. (1998) Reflections on a voice-centred relational method. *In:* Ribbens, J., Edwards, R. eds. *Feminist dilemmas in qualitative research: public knowledge and private lives.* London: Sage.

Mauthner, N.S., Doucet, A. (2003) Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology.* 37(3): 413-431.

Mauthner, N.S., Doucet, A. (2008) 'What can be known and how? narrated subjects and the listening guide'. *Qualitative Research.* 8: 399-409.

McEvoy, P. (2002) Interviewing colleagues: addressing the issues of perspective, inquiry and representation. *Nurse Researcher.* 9(2): 49-58.

McKenna, H., Hasson, F. (2002) A study of skill mix issues in midwifery: a multi-method approach. *Journal of Advanced Nursing.* 37(1): 52-61.

McKenna, H., Hasson, F., Keeney, S. (2004) Patient safety and quality of care: the role of the healthcare assistant. *Journal of Nursing Management.* 12 (6): 422-459.

Merton, R.K. (1957) Social theory and social structure. Glencoe. IL: The Free Press. Cited In: Macdonald, K.M. (1995) *The sociology of the professions*. London: Sage.

Mills, C.W. (1951) *White collar. the American middle class.* New York: Oxford University Press.

Mizra, H.S. (1997) *Black British feminism*. London and New York: Routledge.

Moran, A., Enderby, P., Nancarrow, S. (2010) Defining and identifying common elements of and contextual influences on the roles of support workers in health and social care: a thematic analysis of the literature *Journal of Evaluation in Clinical Practice.* 17(6): 1191–1199.

Moran, A., Nancarrow, S., Enderby, P., Bradburn, M. (2012) Are we using support workers effectively? the relationship between characteristics and support worker utilisation in older people's community-based services in England. *Health and Social Care in Community.* 20(5): 537-549.

Morley, L. (1996) Interrogating patriarchy: the challenges of feminist research. *In:* Morley, L. Walsh, V. eds. *Breaking boundaries: women in higher education.* London: Taylor and Francis.

Morse. J.M. ed. (1991) *Qualitative nursing research a contemporary dialogue.* London: Sage.

Morse, J.M., Barrett, M., Mayan, M., Olsen, K., Spiers, J. (2002) Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods.* 1(2): 1-19.

Muller-Smith, P. (1997) Learning to learn: step one for survival in the new paradigm. *Journal of PeriAnesthesia Nursing.* 12(4): 289-292.

Nancarrow, S. A., Borthwick, A.M., (2005) Dynamic professional boundaries in the healthcare workforce. *Sociology of Health and Illness,* 27(7)*:* 897-919.

Neuman, W.L. (1994) *Social research methods qualitative and quantitative approaches.* Massachusetts: Allyn and Bacon.

NHS Employers (2006), *Maternity support workers: enhancing the work of the maternity team.* London: NHS Employers.

NHS Employers (2011), *Enhancing employment practice to increase quality and safety.* London: NHS Employers.

NICE (2006) (National Institute for Health and Clinical Excellence) *Postnatal care-routine care for women and their babies.* London: NICE

NICE (2008a) (National Institute for Health and Clinical Excellence) *Antenatal care-routine care for the healthy pregnant woman.* London; NICE

NICE (2008b) (National Institute for Health and Clinical Excellence) *A peer programme for women who breastfeed- a commissioning guide implementing NICE guidance.* London: NICE.

NLIAH (National Leadership and Innovations Agency for Healthcare): *All Wales Guidelines for Delegation;* September 2010. Available at: [https://www.wales.nhs.uk/sitesplus/documents/829/NLIAH] accessed 01/11/13

NMC (2004) *Guidance on provision of midwifery care and delegation of midwifery care to others.* NMC Circular, London: NMC.

NMC (2010) Advice on accountability for registered nurses *Available at:* [https://www.nmc-uk.org/Nurses-andmidwives/Advice-by-topic/A/Advice/Accountability/] accessed 01/11/13.

Nurses (Amendment) Act (1961). HMSO: London.

Oakley, A. (1974) *Woman's work.* New York: Pantheon.

Oakley, A. (1981) Interviewing woman: a contradiction in terms. *In:* Roberts, H., ed. *Doing feminist research.* London: Routledge and Kegan Paul.

Oakley, A. (1993) *Essays on women medicine and health.* Edinburgh: Edinburgh University Press.

Olesen, V. (1994) Feminisms and qualitative research. *In:* Denzin, N.K., Lincoln, Y.S. eds. *Handbook of qualitative research.* London: Routledge and Keegan Paul.

Oliver, D, Serovich, J., Mason, T. (2005). Constraints and opportunities with interview transcription: towards reflection in qualitative research. *Social Forces.* 84(2):1273-1289.

Paliadelis, P., Cruickshank, M. (2008) Using a voice centred relational method of data analysis in a feminist study exploring the working world of nursing unit managers. *Qualitative Health Research.* 18: 1444-1453.

Parish, C. (2008) Nurse learn how working smarter creates more time to care. *Nursing Standard.* 22(41): 12.

Parker, I. (2005) *Qualitative psychology- introducing radical research.* Buckingham, UK: Open University Press.

Parkin, F. (1979) *Marxism and class theory. a bourgeois critique*. London: Tavistock.

Parsons, T. (1954) Professions and social structure. *In:* Essays in sociological theory. Glencoe, IL: The Free Press.

Perks, R.W. (1993). *Accounting and society.* London: Chapman and Hall .

Platt, J. (1981) On interviewing one's peers. *The British Journal of Sociology.* 32(1): 75-91.

Plummer, M., Young, L. (2009) Grounded theory and feminist enquiry: revitalising links to the past. *Western Journal of Nursing Research.* 32(3): 305-321.

Polit, D., Beck, C. (2008) *Nursing research: generating and assessing evidence for nursing practice.* London: Lippincott Williams and Wilkins.

Rapley, T. (2004) Interviews *In:* Seale, C., Gobo, G., Gubrium, J., Silverman, D. eds. *Qualitative research practice*. London: Sage.

RCM (2010) *Royal College of Nursing (RCN): Position statement maternity support workers.* London: Royal College of Midwives.

RCN (2008) *Royal College of Nursing (RCN): Health care assistants and assistant practitioners. Delegation and Accountability*. London: RCN.

RCN (2010) *Royal College of Nursing (RCN): Assistant Practitioner Scoping Project*. [www.rcn.org.uk/__data/assets/pdf_file/0003/379155/003880.pdf] accessed 01/11/13

RCN (2011) *Accountability and delegation: what you need to know. the principles of accountability and delegation for nurse students, health care assistants and assistant practitioners*. London: RCN.

Reinharz, S. (1992) *Feminist methods in social research*. Oxford: Oxford University Press.

Renfrew, M.J., Wallace, L.M., D'Souza, L., McCormick, F., Spiby, H., Dyson, L. (2005) *The effectiveness of public health interventions to promote the duration of breastfeeding: systematic reviews of the evidence*. London: NICE

Reynolds, T. (2002) Rethinking a black feminist standpoint. *Ethic and Racial Studies.* 25: 591-606.

Ribbens, J. (1989) Interviewing: an unnatural situation. *Women's Studies International Forum.* 12(6): 579-592.

Richardson, L. (2000) Evaluating ethnography. *Qualitative Inquiry.* 6: 253-256.

Roberts, H. ed. (1981) *Doing feminist research*. London, England: Routledge and Keegan Paul.

Robson, C. (1993) *Real world research.* Oxford: Blackwell.

Robson, C. (2002) *Real world research.* 2nd edn. Oxford: Blackwell.

Rogers, M. (2005). Liberal feminism. *In:* Ritzer, G. ed. *Encyclopaedia of social theory.* Thousand Oaks, CA: Sage.

Rolfe, G. (2006) Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing.* 53(3): 304-310.

Rowland, B. (1981) *Medieval guide to women's health.* London: Croom Helm.

Rubin, G. (1975) The traffic of women *In:* Reiter, R. ed. *Toward* an anthropology of women. New York: Monthly Review Press.

Rubin, H. J. & Rubin, I. S. (1995). *Qualitative interviewing: The art of hearing data.* Thousand Oaks, CA: Sage

Sandelowski, M. (1991) Telling stories: Narrative approaches in qualitative research. *IMAGE: Journal of Nursing Scholarship*. 23: 161-166.

Sanderson, S.K. (2001) *The evolution of human sociality.* Maryland: Rowman and Littlefield.

Schuetz, A. (1944) The stranger: an essay in social psychology. *American Journal of Sociology.* 50: 499-507.

Silverman, D. ed. (2004) *Qualitative research; theory method and practice* 2nd edn. London: Sage.

Simmons, M. (2007) Insider ethnography: tinker, tailor, researcher or spy? *Nurse Researcher* 14: 7–17.

Smith, D. (1974) Women's perspective as a radical critique of sociology. *Sociological Inquiry.* 4: 1-13.

Smith, L. (2005) On tricky ground: researching the native in the age of uncertainty. *In:* Denzin, N.K., Lincoln, Y.S. eds. *The sage handbook of quality research.* 3rd edn. Thousand Oaks, CA: Sage.

Speedy, S. (1991) The contribution of feminist research. *In:* Gray, G., Pratt, R. eds. *Towards a discipline of nursing.* Melbourne; Churchill Livingstone.

Stacey, J. (1991) Can there be a feminist ethnography? *In:* Berger-Gluck, S., Patai, D. eds. *Women's words: the feminist practice of oral history.* New York and London: Routledge.

Stanley, L., Wise, S. (1983) *Breaking out: feminist consciousness and feminist research.* London: Routledge and Keegan Paul.

Stanley, L., Wise, S. (1993) *Breaking out again: feminist ontology and epistemology.* London: Routledge.

Stephens, E. (1999) Why aren't midwives feminists? *British Journal of Midwifery.* 7(8): 476.

Stephenson, J. B., Greer, L.S. (1981). Ethnographers in their own cultures: two Appalachian cases. *Human Organisation.* 40(2): 123-130.

Stewart, J., O'Halloran, C., Barton, J.R., Singleton, S.J., Harrigan, P., Spencer, J. (2000) Clarifying the concepts of confidence and competence to produce appropriate self-evaluation measurement scales. *Medical Education.* 34: 903-9.

Stokes, J., Warden, A. (2004) The changing role of the healthcare assistant. *Nursing Standard.* 18(5): 33-37.

Taylor, J., Gilligan, C., Sullivan, A. (1995) *Between voice and silence.* Cambridge MA: Harvard University Press.

Thornley, C. (2000) A question of competence? re-evaluating the roles of the nursing auxiliary and health care assistant in the NHS. *Journal of Clinical Nursing.* 9(3): 451-458.

Tobin, T.A., Begley, C.M. (2004) Methodological rigour within a qualitative framework. *Journal Advanced Nursing.* 48(4): 388-396.

Tong, R.P. (1998) *Feminist thought: a more comprehensive introduction.* Boulder, Colorado: Westview Press.

Towler, J., Brammall, J. (1986) *Midwives in history and society.* London: Croom Helm.

Tracy, S. (2010) Qualitative quality: eight 'big tent' criteria for excellent qualitative research. *Qualitative Inquiry.* 16(10): 837-851.

Trinh, T.M. (1991) *Framer framed.* New York: Routledge.

UKCC (1986) *Project 2000 a preparation for nursing midwifery and health visiting.* UKCC: London

Wakefield, A., Spilsbury, K., Atkin, K., McKenna, H., Borgin, G., Stuttgard, L. (2009) Assistant or substitute: exploring the fit between national policy and local practice realities of assistant practitioner job descriptions *Health Policy* 90: 286–295

Walby, S. (1990) *Theorising patriarchy.* Oxford: Basil Blackwell.

Watts, J. (2006) The outsider within dilemmas of qualitative feminist research within a culture of resistance. *Qualitative Research.* 6(3): 385-402.

Webb, C. (1983) Feminist methodology in nursing research. *Journal Advanced Nursing.* 9: 249-256

Webb, C. (1993) Feminist research; definitions, methodology, methods and evaluation. *Journal of Advanced Nursing.* 18(3): 416-423.

Weber, M. (1949) *The methodology of the social sciences.* Glencoe, IL: Illinois Free Press.

Weick, K.E. (2007) The generative properties of richness. *Academy of Management Journal. 50*: 14-19.

Wendler, D., Grady, C. (2008) What should research participants understand to understand they are participants in research? *Bioethics.* 22(4): 203-208.

Wheeler, J. (2001) How to delegate your way to a better nursing life. *Nursing Times,* 97(36): 34.

Wiegers, T.A. (2009) The quality of maternity care services as experienced by women in the Netherlands *BMC Pregnancy and Childbirth*, 9 (18) *Available at:* [http://www.biomedcentral.com/1471-2393/9/18] last accessed 01/11/13.

Williamson, T.K. (2007) The individual in research. *In:* Long, T., Johnson, M., eds. *Research ethics in the real world: issues and solutions in health and social care.* Edinburgh: Churchill Livingstone/Elsevier.

Wise, S. (1987) A framework for discussing ethical issues. *In:* Griffiths, V., Humm, M., O'Rourke, R., Barsleer, J., Poland, F., Wise, S. eds. *Studies in sexual politics No. 19.* Dept. of Sociology, Manchester, England: University of Manchester.

Witz, A. (1992) *Professions and patriarchy.* London: Routledge.

Wood, J.T (2005) *Gendered lives: communication, gender and culture.* 6th edn. Belmont, CA: Wadsworth/Thompson Learning.

Appendix 1

PARTICIPANT INFORMATION SHEET

Title of Project: Midwifery Support Workers & Midwives
Name of Researcher: Debbie Ellis

Midwifery Support Workers And Midwives
You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.
Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
- This project plans to explore the working relationships that exist between Midwifery Support Workers and the Midwives who work together in the community within [Hospital name] Hospitals NHS Foundation Trust.
- Findings will be fed back into maternity services aiming to improve the working relationships that already exist between Midwifery Support Workers and Midwives.
- This project is also for the researcher to undertake further study i.e. Master of Philosophy

Why have I been chosen?
All Midwifery Support Workers in the community will be approached to take part in the study. Community Midwives who work closely with the Midwifery Support Workers will be approached to take part in the study.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?
Midwifery Support Workers
Each Midwifery Support Worker will have an initial interview that will take approximately one hour. A follow up shorter interview may be needed at a later date.

Midwives
Each Midwife interview will take approximately one hour.

Will my taking part in this study be kept confidential?
Yes. All the information about your participation in this study will be kept confidential.

Interviews will be tape recorded, and professionally transcribed. Tapes will be wiped and the transcripts coded so participants will be anonymous.

The data will be stored in a locked cupboard with only the researcher and the researcher's supervisor allowed access.

What will happen to the results of the research study?
The findings will be available at the end of the project about 18 months after the interviews.

The results will be published and findings made available through local presentations within maternity services.

Concerns/Complaints

Any concerns or complaints about the way you have been dealt with during the study or any possible harm you might suffer can be addressed to:

Debbie Ellis (Researcher) Midwife, Place of work Tel No.

Mavis Kirkham (Researcher's Supervisor) Professor of Midwifery, Place of work Tel No.

Name of Head of Midwifery, Place of work Tel No.

Appendix 2

CONSENT FORM

Centre Number:

Study Number:
Participant Identification Number:

Title of Project: Midwifery Support Workers & Midwives
Name of Researcher: Debbie Ellis

Please initial box

1. I confirm that I have read and understand the information sheet for the above study. (date ……/……/…… version no …………)
I have had the opportunity to consider the information, questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

☐

3. I agree to take part in the above study.

☐

_____   _____   _____
Name of Participant   Date   Signature

_____   _____   _____
Researcher   Date   Signature

_____   _____   _____
Name of person taking consent   Date   Signature
(if different from researcher)

When completed, copy for participant, copy for researcher site file

Appendix 3

INTERVIEW SCHEDULE FOR INTERVIEWS WITH MSWS (version 1)

Title of Project: Midwifery Support Workers & Midwives

Ensure information sheet has been given previously.
Gain written consent before undertaking and recording interview.

- Greet Participant.

- Check understanding of why research being undertaken

- Introduction-background information/age/experience

- What did you do before you became an MSW in the community?

- How long did you do that?

- Thinking back what is that attracted you to working in the community?

- Is the experience as you imagined it would be?

- How does it compare to you previous experience of working?

- Thinking how you work alongside the midwives:

- How do you find working in the community?

- Has anything changed since you first started working in the community?

- What do you enjoy about the work you do?

- What are the least enjoyable aspects?

- How would you view your relationship with the different midwives you work alongside?

- Are there any areas that you find difficult or that could be improved?

- If you have a message for the midwives you work alongside what is it?

Thank the participant and request that further follow up may be needed and ask for consent, for any further interviews.

Appendix 4

INTERVIEW SCHEDULE FOR INTERVIEWS WITH MIDWIVES (version 1)

Title of Project: Midwifery Support Workers & Midwives

Ensure information sheet has been given previously.
Gain written consent before undertaking and recording interview.

- Greet Participant.

- Check understanding of why research being undertaken

- Introduction-background information/age/experience

- Thinking how you work alongside the MSWs:

- What experience do you have of working alongside an MSW in the community? Length/Frequency/

- How would you describe your day-to-day interaction with MSWs?

- How have you found working with MSWs in the community?

- Has anything changed since MSWs started working in the community?

- How would you view your relationship with the different MSWs you work alongside?

- How do you see the role of the MSW in community? Is there a need for this type of role?

- Can you see any benefits of having MSWs in community?

- Can you describe how you feel about working with MSWs?

- Are there any areas that you find difficult or that could be improved?

- If you have a message for the MSWs you work alongside what is it?

Thank the participant and request that further follow up may be needed and ask for consent, for any further interviews.

Appendix 5

INTERVIEW SCHEDULE FOR INTERVIEWS WITH MSWs (Version2)

Title of Project: Exploring Working Relationships Between MSWs & Midwives

Ensure information sheet has been given previously.
Gain written consent before undertaking and recording interview.

- Greet Participant.

- Check understanding of why research being undertaken

- Introduction-background information/age/experience

- How does your previous work experience impact on your current post?

- How important is your previous experience in the work of an MSW?

Thinking how you work alongside the midwives:

- Is the experience as you imagined it would be?

- How does it compare to your previous experience of working?

- How would you describe your day-to-day interaction with midwives?

- How have you found working with midwives in the community?

- Has anything changed since MSWs started working in the community?

- How would you view your relationship with the different midwives you work alongside?

- How do you see the role of the MSW in community? Is there a need for this type of role?

- Can you see any benefits of having MSWs in community?

- Can you describe how you feel about working with midwives?

- Are there any areas that you find difficult or that could be improved?

- Has anything changed since MSWs started working in the community?

- If you have a message for the midwives you work alongside what is it?

Thank the participant and request that further follow up may be needed and ask for consent, for any further interviews.

Appendix 6

INTERVIEW SCHEDULE FOR INTERVIEWS WITH MIDWIVES (Version 2)

Title of Project: Exploring Working Relationships Between MSWs & Midwives

Ensure information sheet has been given previously.
Gain written consent before undertaking and recording interview.

- Greet Participant.

- Check understanding of why research being undertaken

- Introduction-background information/age/experience

- How does the previous work experience impact on the MSWs current post?

- How important is the previous experience in the work of an MSW?

Thinking how you work alongside the MSWs:

- Is the experience as you imagined it would be?

- How does it compare to your previous experience of working?

- How would you describe your day-to-day interaction with MSWs?

- How have you found working with MSWs in the community?

- Has anything changed since MSWs started working in the community?

- How would you view your relationship with the MSWs you work alongside?

- How do you see the role of the MSW in community? Is there a need for this type of role?

- Can you see any benefits of having MSWs in community?

- Can you describe how you feel about working with MSWs?

- Are there any areas that you find difficult or that could be improved?

- Has anything changed since MSWs started working in the community?

- If you have a message for the MSWs you work alongside what is it?

Thank the participant and request that further follow up may be needed and ask for consent, for any further interviews.

Appendix 7

INTERVIEW CHECKLIST

Name:

_____

Date/time:

_____

Venue:

_____

Day of interview:
-arrive early
- check room
- chairs at 90 degree angles
- table for tape recorder/drinks

Remember:
-participant information sheets
-consent forms
-interview guide
-tape recorder
-spare batteries
-phone on silent
-pens
-field note journal
-names/numbers of counsellors
-names and numbers of HoM and supervisor

Before interview:
-give out participant information sheet
-get consent sheet signed
-explain study
-remind participant can withdraw consent at any time

At end of interview:
-ask participants if they will take part in a second interview if needed
[YES/NO]
-further info/complaint procedure/access to counselling service via research supervisor or Head of Midwifery see PIC sheet

After interview:
-field notes
- document any significant features noise/interruptions/door handle conversations
document thoughts/feelings of significance

Appendix 8

Interview Prompts for MSWs and Midwives

Introduction

Thanks for taking part. This study is looking at the role of the MSW and finding out form the people involved how it I working out in the community for the MSWs and midwives. I hope as we start to talk this will feel more like a conversation. The information you choose to share is confidential. You will be given a cover name for the study however because I will be using your words and most staff know each other you or others may be recognised.

Background info

Tell me a little about your background… working/training/experience

How did you come to work in the community…?

Relationships

Tell me a little about how you find working together…

Tell me about what you like about working together…

Tell me about what you dislike about working together…

Can you explain to me about any good points of working together…?

Can you explain to me about any difficulties of working together…?

Tell me a little about how you manage the difficult parts…

How do you find working with different MSWs OR MWs…?

Tell me a little how you manage challenging situations…

Roles

How have you found working… in your new role (MSWs) OR alongside MSWs (MWs)

Tell me how do you know whose job is whose…

Tell me how do you decide what work to…take (MSWs) OR delegate (MWs)

Tell me how you know what is a job for a midwife…

Tell me how you know what is a job for a midwifery support worker…

Tell me how you know the difference between the two role…

Finish

Thank them for their willingness to share.

Let them know the Trust will be informed when the study is published.

Appendix 9

Worked example of VCRM

Reading 1

456 **DE:**
457 ...since being in hospital. So looking at your team members, how did they see your role, you
458 know...
459 **Helen:**
460 Do you mean when I first came out?
461 **DE:**
462 Yeah when you first came out and how maybe it's changed now.
463 **Helen:**
464 When I first came out there was-uh a very senior midwife out here, who thought, "Uh,
465 healthcare, midwifery support worker, what on earth can they do out here, because it's
466 community it's not the hospital. You know there's no beds to make, there's no tea to give
467 out and..." I worked for a few months with her and I was very surprised at what she said,
468 she said, "Well Helen..." she said "...I didn't think support workers had a role out here, but
469 you've proved me wrong."
470 **DE:**
471 Well there you go. Wow!
472 **Helen:**
473 And I've got that from a lot of my colleagues. Uh, how if I'm off you know, "Oh gosh we
474 missed you." And that's...that's what you want Debbie. Uh, not for myself, but for the role.
475 That you are needed and you can use your skills and you help the team, because it's all team
476 work out here as you know...
477 **DE:**
478 Yeah.
479 **Helen:**
480 ...and you've got to be able to, you know can you will you and you've got to be able to say,
481 "Yes I can or no I can't." And within the hospital you would...you're only asked to do one
482 job at a time. Out here you're asked to do [laughs] several as you know. You get your
483 workload in the morning and then they phone through the day and you've got to...to work
484 your day through on your own.
485

| Comment [D1]: Good open lead in |
| Comment [D2]: My insider state is showing through I know the role has changed |
| Comment [D3]: Implies a more experienced midwife, maybe someone who is older and I possibly recognise to which midwife Helen is referring |
| Comment [D4]: Work of a HCA in hospital menial tasks, they can do so much more |
| Comment [D5]: Good for Helen she's really worked hard to make this job happen |
| Comment [D6]: Did I really say that. I'm supposed to be objective |
| Comment [D7]: Tells me other midwives are coming to accept the role |
| Comment [D8]: Is this about Helen or the role? |
| Comment [D9]: Helen again refers to my inside knowledge of the organisation |
| Comment [D10]: Showing her confidence |
| Comment [D11]: Straightforward, not as complex as community working |
| Comment [D12]: Refers to the midwives in the same team |
| Comment [D13]: |
| Comment [D14]: I am able to empathise as I too work in a similar way |

Reading 2

456   **DE:**
457   ...since being in hospital. So looking at your team members, how did they see your role, you
458   know...
459   **Helen:**
460   Do you mean when I first came out?
461   **DE:**
462   Yeah when you first came out and how maybe it's changed now.
463   **Helen:**
464   When I first came out there was-uh a very senior midwife out here, who thought, "Uh,
465   healthcare, midwifery support worker, what on earth can they do out here, because it's
466   community it's not the hospital. You know there's no beds to make, there's no tea to give
467   out and..." I worked for a few months with her and I was very surprised at what she said,
468   she said, "Well Helen..." she said ."..I didn't think support workers had a role out here, but
469   you've proved me wrong."
470   **DE:**
471   Well there you go. Wow!
472   **Helen:**
473   And I've got that from a lot of my colleagues. Uh, how if I'm off you know, "Oh gosh we
474   missed you." And that's...that's what you want Debbie. Uh, not for myself, but for the role.
475   That you are needed and you can use your skills and you help the team, because it's all team
476   work out here as you know...
477   **DE:**
478   Yeah.
479   **Helen:**
480   ...and you've got to be able to, you know can you will you and you've got to be able to say,
481   "Yes I can or no I can't." And within the hospital you would...you're only asked to do one
482   job at a time. Out here you're asked to do [laughs] several as you know. You get your
483   workload in the morning and then they phone through the day and you've got to...to work
484   your day through on your own.

I Poem

I first… they do… I… I… she said… she said… I… I've got… I'm off… we… you… you want… you
are… you can… you help… you know... you've got… you know… you will… you and… you've
got… I can… I can't… you would… you're only… you're asked… you know… your workload…
you've got… your day… your own.

485

Reading 3

456 **DE:**
457 ...since being in hospital. So looking at your team members, how did they see your role, you
458 know...
459 **Helen:**
460 Do you mean when I first came out?
461 **DE:**
462 Yeah when you first came out and how maybe it's changed now.
463 **Helen:**
464 When I first came out there was-uh a very senior midwife out here, who thought, "Uh,
465 healthcare, midwifery support worker, what on earth can they do out here, because it's
466 community it's not the hospital. You know there's no beds to make, there's no tea to give
467 out and..." I worked for a few months with her and I was very surprised at what she said,
468 she said, "Well Helen..." she said ."..I didn't think support workers had a role out here, but
469 you've proved me wrong."
470 **DE:**
471 Well there you go. Wow!
472 **Helen:**
473 And I've got that from a lot of my colleagues. Uh, how if I'm off you know, "Oh gosh we
474 missed you." And that's...that's what you want Debbie. Uh, not for myself, but for the role.
475 That you are needed and you can use your skills and you help the team, because it's all team
476 work out here as you know...
477 **DE:**
478 Yeah.
479 **Helen:**
480 ...and you've got to be able to, you know can you will you and you've got to be able to say,
481 "Yes I can or no I can't." And within the hospital you would...you're only asked to do one
482 job at a time. Out here you're asked to do [laughs] several as you know. You get your
483 workload in the morning and then they phone through the day and you've got to...to work
484 your day through on your own.

Reading 4

456 **DE:**
457 ...since being in hospital. So looking at your team members, how did they see your role, you
458 know...
459 **Helen:**
460 Do you mean when I first came out?
461 **DE:**
462 Yeah when you first came out and how maybe it's changed now.
463 **Helen:**
464 When I first came out there was-uh a very senior midwife out here, who thought, "Uh,
465 healthcare, midwifery support worker, what on earth can they do out here, because it's
466 community it's not the hospital. You know there's no beds to make, there's no tea to give
467 out and..." I worked for a few months with her and I was very surprised at what she said,
468 she said, "Well Helen..." she said ."..I didn't think support workers had a role out here, but
469 you've proved me wrong."
470 **DE:**
471 Well there you go. Wow!
472 **Helen:**
473 And I've got that from a lot of my colleagues. Uh, how if I'm off you know, "Oh gosh we
474 missed you." And that's...that's what you want Debbie. Uh, not for myself, but for the role.
475 That you are needed and you can use your skills and you help the team, because it's all team
476 work out here as you know...
477 **DE:**
478 Yeah.
479 **Helen:**
480 ...and you've got to be able to, you know can you will you and you've got to be able to say,
481 "Yes I can or no I can't." And within the hospital you would...you're only asked to do one
482 job at a time. Out here you're asked to do [laughs] several as you know. You get your
483 workload in the morning and then they phone through the day and you've got to...to work
484 your day through on your own.

Theming

456 **Interviewer:**
457 ...since being in hospital. So looking at your team members, how did they see your role, you
458 know...
459 **Helen:**
460 Do you mean ==when I first came out==?
461 **Interviewer:**
462 Yeah when you first came out and how maybe it's changed now.
463 **Helen:**
464 When I first came out ==there was-uh a very senior midwife out here, who thought, "Uh,==
465 ==healthcare, midwifery support worker, what on earth can they do out here, because it's==
466 ==community it's not the hospital. You know there's no beds to make, there's no tea to give==
467 ==out and..." I worked for a few months with her and I was very surprised at what she said,==
468 ==she said, "Well Helen..." she said ."..I didn't think support workers had a role out here, but==
469 ==you've proved me wrong."==
470 **Interviewer:**
471 Well there you go. Wow!
472 **Helen:**
473 ==And I've got that from a lot of my colleagues. Uh, how if I'm off you know, "Oh gosh we==
474 ==missed you."== And that's...that's what you want Debbie. Uh, not for myself, but for the role.
475 That you are needed and ==you can use your skills and you help the team==, because it's all team
476 work out here as you know...
477 **Interviewer:**
478 Yeah.
479 **Helen:**
480 ==...and you've got to be able to, you know can you will you and you've got to be able to say,==
481 ==="Yes I can or no I can't==." And within the hospital you would...you're only asked to do one
482 job at a time. Out here you're asked to do [laughs] several as you know. ==You get your==
483 ==workload in the morning and then they phone through the day and you've got to...to work==
484 ==your day through on your own.==

Colour coding for basis themes

🟨	Exciting times, inciting times
🟦	Defining the role
🟥	Registration & accountability
🟦	Negotiating roles
🟩	Gatekeeping
🟩	New beginnings

🟪	Suspicious minds
🟥	Moving and improving
🟨	Impressions of a different kind
⬜	Value of education and training
⬛	Worth of experience and skills

Appendix 10

Description of the MSWs and Midwives.

Bridget, midwife (pilot)

Bridget is a wife and a mother and had been a midwife for many years, working mainly in the community. As a young midwife she had worked across the whole town area but eventually settled to live and work in one of the town's villages and has done so for a number of years. Bridget was also a supervisor of midwives and provided information and support to other midwives, particularly on community matters. However, Bridget had not worked in hospital for a long time and therefore had no experience of working alongside healthcare assistants, so when faced with working alongside an MSW in her own community setting she had no vision of how the roles would work together. Initially her thoughts were that 'I don't think there's any work for her' believing that community midwives work was just that, and stated she 'was sceptical about whether a healthcare assistant could be of any benefit' to the midwives in the team. Nevertheless, Bridget recognised that midwifery could not stand still and commented that 'community midwives role has got to be, has got to change we can't just do what we did ten years ago'. Furthermore, Bridget found her attitude towards the MSW role changed and in due course began to appreciate 'there is a place for them'.

Bridget and I worked together in the same team for about a year before an MSW was allocated to the team, and then only for a brief period of time before Carmel (the MSW) was moved to another team.

Kate, midwifery support worker (pilot)

Kate started work as a nursing auxiliary and 'ended up taking my NVQ level 2' to become a healthcare assistant. Later it was Kate who became the first MSW in community. This was initially on a trial basis, and as this new programme was seen as 'successful' further MSWs were introduced into the community setting, with Kate acting as a role model and a trainer for the newer recruits. Kate describes herself as 'ageist' as she sees the MSW role is for 'somebody maybe 25 plus'. She considers herself a 'mature woman' as she is over fifty and married with a grown up daughter. After working in the community of one hospital for approximately two and a half years Kate transferred across to the Trust's hospital in a neighbouring county, once again to trail blaze the role of the MSW. Kate considers she is experienced enough to work independently but humble enough to recognise 'you can't be somebody who comes out here with a chip on your shoulder' because 'you've got to have good relationships with your midwives'.

Kate and I started working in the community at the same time. We both worked within the same team but did not work alongside each other for a number of months and then only sporadically, as Kate was undergoing training for her new role. I then moved from this team to work in the town's southern villages (with Bridget) leaving Kate to work in the team. Kate became partly responsible for the training of other MSWs as they entered their community roles. Kate's other team members at this time included the midwives Wendy and Rachel.

Heidi, midwife

Heidi is another community midwife who has worked in the same village for a number of years. She is married with a teenage son. However Heidi had experienced loss and sadness in becoming a mother and yet, was able to share her personal experiences with dignity and always seemed to have a positive outlook on life. Heidi had a buoyant personality and brought youthfulness into her work and although in her early fifties she could be perceived to be much, although at one point she did liken herself to 'an old granny'. Heidi was 'thrilled and could see the potential' in employing MSWs in the community. However she expressed her frustration with how another of the midwives not only tried to monopolise the work of the MSW but also tried to delegate inappropriate work to the MSW. In a bid to modify the midwife's practice Heidi set about arming the MSW with defensive/combative skills and spoke of increasing the MSWs confidence and assertiveness to be able to say 'no'.

Heidi worked in the same team as Gillian-MSW. Later Heidi moved to the town's southern team within which I was based, and so we became team members.

Gillian, midwifery support worker

Gillian was a young thirty something and a single parent caring for her young son, having split up with her partner some time ago. Gillian had moved to the team in the south west of town three years ago, having served her six months apprenticeship in the training team shortly after returning to work from maternity leave. She found the move unsettling and felt 'very uncertain' and stated that she 'didn't want to come', and relocate into a new team. Initially Gillian worked alongside one particular midwife, and then gradually began working with some of the others as time wore on. However this caused some friction between the original midwife and the more recent ones that became more accepting of her role. It was at his point Heidi begun coaching Gillian to become more confident and assertive to avoid being controlled by one midwife. All the midwives except one in this team were over the age of fifty. Gillian perceived that it was not particularly older midwives who were less supportive of the role and avoided using her skills, she identified it was the midwives who struggled with any new changes were the ones who had been in the team a long time. Gillian noted 'even though they were all lovely and they all like, you know were lovely to me' these midwives found it difficult to accept her role and she explained that 'they weren't willing to accept me……the midwifery support worker'. They found it difficult to adjust to this new way of working. Plans

were made for Gillian to work alongside these more stalwart midwives in a clinic setting, to demonstrate Gillian's skills and experience as an MSW. Little by little the midwives attitudes changed and they became more supportive of the MSW role. Gillian reported it had only taken two and a half years.

Gillian was in the same team as Heidi-midwife.

Wendy, midwife

Wendy was in her late thirties and had been a community midwife for nearly four years having previously worked as a hospital midwife for fourteen years. Wendy had a husband and three young children. Recently she had taken extended time off work and used it as a sabbatical. Wendy revealed that she had contemplated becoming a health visitor at around the same time she had applied for a community post but was glad she hadn't and reflected that 'community midwifery is where I should have been'. As a hospital midwife Wendy had had some experience of working with all the MSWs except Alex, in their roles as healthcare assistants on the maternity wards. Now working full time in the training team she had experienced working alongside all the MSWs. She compartmentalised their present skills and abilities according to the amount of experience under her own headings of 'very experienced', 'fairly experienced' and 'sort of experienced'. This equated to the amount of experience and time spent on the maternity wards, and how confident she felt about the skills and abilities to work independently as MSWs in the community. Throughout this time Wendy expressed her dismay that the MSWs practice had become somewhat limited to 'solely breastfeeding support'. Moreover, she felt frustrated that the 'goalposts had been moved' without communicating this change to all the midwives. She went onto question whether this action was in response to the limited ability and experience of one MSW or whether it really was a question of following key NHS drivers to improve breastfeeding initiation and rates of duration.

Wendy had worked with Rachel-midwife, and MSWs Kate, Carmel, Gillian, Kath and Alex.

Rachel, midwife

Rachel was a single thirty-something midwife. She had trained initially as a nurse and then completed the degree course in eighteen months. Rachel confirmed that she had no children. Her role as a community midwife began a few months after Kate had started work as an MSW. Similar to Wendy she had had experience of working with all the support workers in the hospital except Alex, as Alex had yet to start as a healthcare assistant on the maternity wards. Rachel therefore had the opportunity to work with all the MSWs in their community role, and looked upon the role in a positive way throughout her interview. She had witnessed how the role had changed as 'the support workers supporting women and not supporting the midwives', although she was unsure 'how the role changes came about'. Rachel describes herself as a person that 'gets on with anybody'. It had been noticed by another midwife, that

Alex an MSW, when 'at a loose end' would visit Rachel's clinic. Rachel reasoned that 'there will be midwives in the team they (the MSWs) feel more comfortable with', and who they 'find more approachable, feel more relaxed with and don't feel daft asking questions with', and offered an example of herself as a midwife on labour ward noting which midwife she would approach should she have any queries. Rachel was also great friends with Kate and Carmel and they socialised together outside of working hours. At the close of the interview when recording had stopped, Rachel asked about how I had found Carmel, as she was aware that I had previously interviewed Carmel. Rachel also knew that I had worked with Carmel before she was moved to the northern team. Her anxiety was obviously around Carmel's health and well-being. I admitted I was concerned about both of these aspects and was really not in a position to divulge any of Carmel's confidences. However I suggested Rachel make herself available and encourage Carmel to talk of her experiences as this may help Carmel.

Rachel worked with Wendy-midwife, and MSWs Kate, Carmel, Gillian, Kath and Alex.

Alex, MSW

Alex had worked in the hospital for about five years starting life as an Operating Department Orderlie within theatres, within the same hospital 'escorting patients down and things like that. She then 'jumped at the chance' to train as a healthcare assistant in theatres as she 'thought it was good experience'. Alex valued her NVQ training and seemed proud of having achieved level 2 status within a six month period. She wanted to 'get my teeth into something different' and 'in theatres obviously you don't get a lot of patient contact' and wanting to experience more patient contact Alex applied for the first advertised post of MSW, along with Helen, Carmel and Gillian. Alex acknowledged that she 'hadn't got the background experience'. Nevertheless 'they did offer me a position as healthcare on the ward' and worked on the maternity wards for eighteen months before reapplying and obtaining a community MSW post. Alex spoke of feeling unprepared for her new role, 'a bit jumped into it' at the beginning. However Alex's interview comprised of three parts. In the first part she only hints at her deeper thoughts and feelings and the interview closes. The next part started at the close of the interview when recording stopped and Alex revealed her real experiences of her role. The third part began after discussing and explaining how he anonymity would be maintained in the research process. Then Alex permitted us to record and capture her true story. Alex spoke of the pressures she felt of trying to imitate the work of Kate the original MSW, who helped train and 'show the ropes' to the newer MSWs and the demands placed on her by the midwives. She 'couldn't see a light…light at the end of the tunnel' and having 'a lot of weight on me shoulders', She felt that she 'just made it ten times worse really, because I wasn't vocal', and unable to admit to her team members she was struggling to cope with the work and the workload, and considered going back to work in the hospital. Alex was single, in her mid-twenties and therefore sought the support of her family, namely her mum and dad. They suggested finding somebody to talk to as 'it needed to come out how I was feeling'. Alex

found the courage to confide in a midwife team member, who helped to turn around her work life. Alex felt that the past months had improved to a greater extent for the better and was 'learning on the other respect to say "no"'. These improvements had occurred in the last six months, eighteen months after Alex had come into post. Alex went on maternity leave later in the year.

Alex worked with midwives Wendy and Rachel.

Frankie, midwife

Frankie was a relatively new addition to the team having only been in post for two years. Previously she had worked in a southern English city. Her experience is wide and varied and reflected in her interview as she explains how other midwifery communities practice. Before moving out into the community Frankie worked for a short time in the local hospital. Frankie had always wanted to be a midwife and felt she had no option and 'had to do nursing first' having 'never wanted to be a nurse'. She had been a midwife for twenty five years and now 'nearing fifty' had started to plan for her retirement. Conversely, she had also laid plans to further her professional career and had organised to undertake a neonatal assessment course. Up until recently the team dynamics of this particular midwifery team had been notoriously poor. Lately however there seemed to have been a marked improvement. Helen (MSW) had joined the team prior to Frankie's arrival. Frankie had had no previous engagement with midwifery support workers and therefore had to learn about the new role as she joined the team. She voiced concerns around MSW training and questioned its reliability and worth measuring it against other national standards of education. Frankie also queried boundary working between MSWs and midwives and the difference between the two. She is proactive in work and forever questioning midwifery practice. Her character put me in mind of that of a shop steward or union worker. Frankie is energetic and dynamic in her nature. She is forward thinking and has an edge and is able to somewhat forecast what may lie ahead and predicts that 'in several years time' the NHS is 'gonna have a relatively young population of midwives who are supported by health support workers'.

Frankie worked with Hannah-midwife and Helen-MSW.

Hannah, midwife

Hannah had worked within the same team for a number of years, and been a community midwife for the greater part of her midwife career. Hannah recalls having had a discussion with other midwives 'probably about twelve, thirteen years back' about the introduction of MSWs in community and recollects 'we all said, "Well, what are they gonna do?' Hannah was another of the midwives who remembered working with SENs and measured skills of the MSWs against those of the SENs. In the community this team was noted for its disjointed working between team members and personality clashes and within the last year there had

been a reshuffling of the midwives bases, as more midwives joined the team. This affected Hannah as she too had moved to a new area whilst remaining in the same team. More recently the team seemed to be more together and I had had the opportunity to observe this at the end of Helen's interview as the team were meeting for lunch. Hannah mentioned working closely with the health visitors that included joint working in the breastfeeding group at the local Children's Centre. It had been difficult to arrange a meeting with Hannah so I had offered to meet her after the breastfeeding group had finished and this good working relationship was apparent as the health visitor suggested she would tidy up to allow us time together for carry out the interview. Hannah also spoke of feeling under pressure with the hospital 'pushing one way' and 'the health visitor team and PCT's pushing another way'. Hannah did not mention her personal life in the interview although she was married with grown up children

Hannah worked with Frankie-midwife and Helen-MSW.

Helen, midwifery support worker

When Helen 'finally got a job in community' she had been working on the wards for about eighteen years, and commented on having worked as domestic in the same areas some years previously. Initially Helen worked as an auxiliary and in more recent years as a healthcare assistant on the maternity wards before taking up the post of midwifery support worker. She joined this team of midwives about two years ago having completed her apprentice time in the training team, a little time before Frankie. She felt 'fortunate' that people 'knew' her from the hospital although, she 'hadn't worked with them for fifteen years', and then only in her role as an auxiliary. She spoke of how busy she was all the time and how midwives 'phone through the day' to pass over more work, but also how she also looked for work, and stated that 'if I go into a room I look round and think "What needs doing?"' Helen also mentioned that she has grown up grandchildren as drew on her personal experiences when she spoke with parents and referred to her own experiences only as an example of how child care changes from one generation to the next and noted, 'I mean my grandchildren weaned ages ago and things change don't they?' Helen also recalled placing the MSW role on a communal noticeboard and commented 'we've got it pinned up somewhere still', in a bid to ensure the midwives understood what work MSWs undertook.

Helen worked with midwives Frankie and Hannah.

Toni, midwife

Toni was married and had two children. Toni had worked as a community midwife in the same place for a number of years. All the midwives were GP attached which meant their caseloads reflected the number of pregnant women registered at a GP practice. The two GP practices in the village had recently moved to brand new purpose built premises and I had arranged to

meet Tony here to undertake her interview. Toni was really conscious that I did not 'tread on any toes', and gave strict instructions where I was to go to, and who I was to approach on entering the building, although she counteracted this and stated the staff were really lovely. Toni worked in the town's northern team and noted 'that our team is the smallest team in (Town Name) and has been for quite some time'. Again there had been 'some staffing changes' that resulted in the team being allocated fewer midwifery hours. Toni recalled approaching the Head of Midwifery and being offered midwifery support worker hours in lieu and therefore, 'we took that rather than nothing'. Toni admitted she was sceptical of the role and saw it as 'a…a cheap form of midwifery'. However, she realised her 'views are not the same now'. Toni acknowledged that the MSW had 'proved to be invaluable', she felt' that we should have had a midwife as well'. Toni had recognised that the MSW 'did not feel needed or appreciated perhaps' by another midwife in the team and had recognised a problem and the team hadn't yet, 'discussed it altogether'. I felt Toni wanted to avoid confrontation and is a reason for including the detailed instructions of meeting up with Toni as a case in point. Toni in later months left the team to take up a post in the hospital.
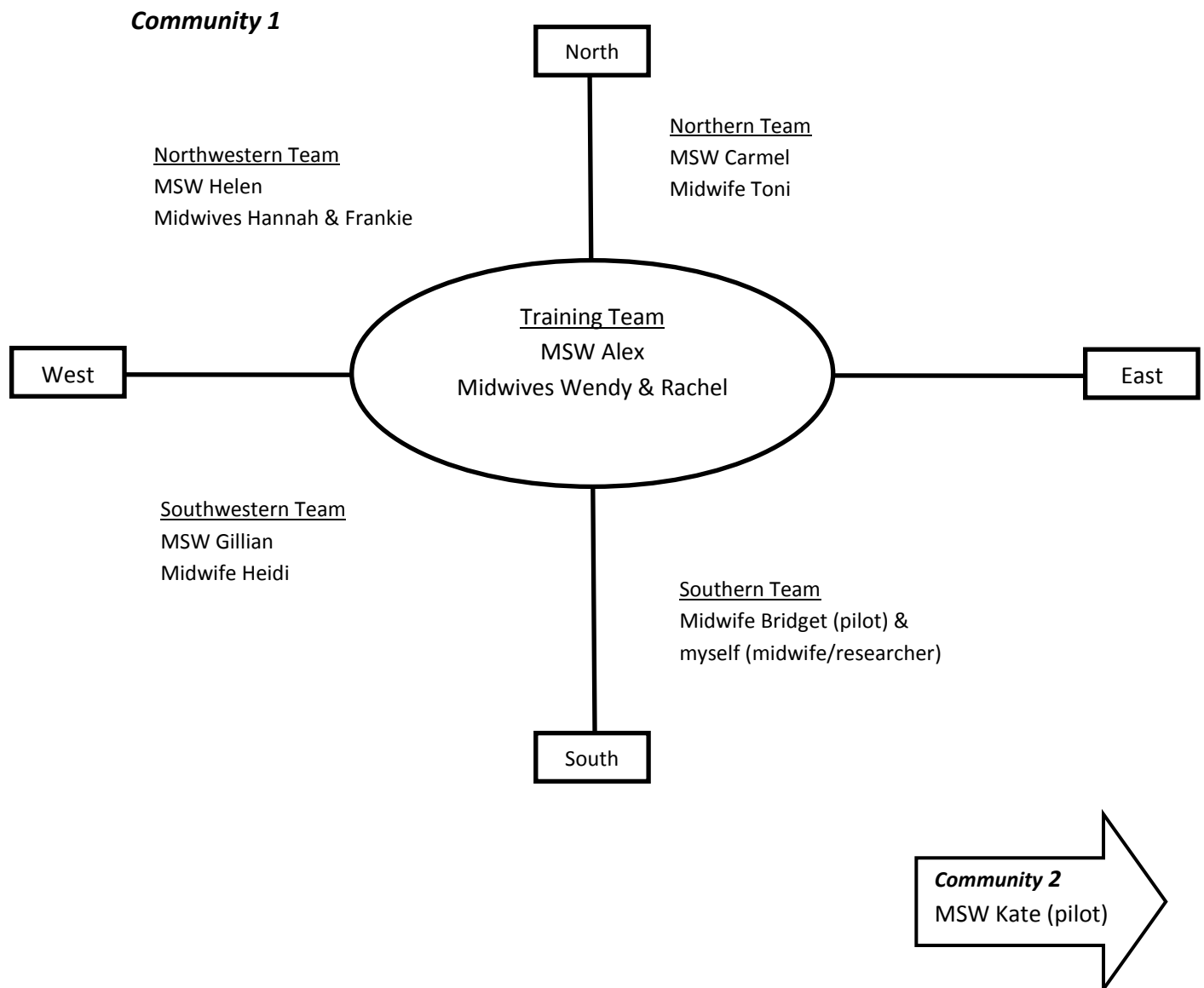
Toni worked with Carmel-MSW.

Carmel, MSW

Carmel was a wife, and had had two children in a previous marriage and now had grandchildren. She had 'worked on ward for twenty two years as a healthcare'. In her interview Carmel mentions work as an auxiliary so part of her healthcare role was as an auxiliary, and I can recall many auxiliaries undertaking NVQ certification on the maternity wards in 1995. She had worked a further four years as an MSW. In the intervening years Carmel witnessed how 'the role's completely turned around, completely changed' and remembers not being allowed to hold a baby for a few weeks when she first started, and recollects thinking ' "I've had two children of me own"'. Carmel had been the second MSW in community, and undertaken her apprenticeship in the training team under the auspices of Kate. Kate and Carmel were already great friends and met quite often on days off. Then she had moved to the town's southern team for a number of months and then moved again to join the northern team as their need was seen to be greater (see Toni's description). It appears that Carmel established herself within the team and worked well with all the midwives. One of the midwives who had 'been here for a long time' had been 'off sick for quite a while' when Carmel joined the team. On her return the midwife requested Carmel's' help in clinics and Carmel remembers 'she begged me to go out with her'. This was the start of a relationship that would undermine Carmel as an MSW and a person, and brought on her ill health. The team knew and understood 'what's happened to me with her' and 'didn't realise it was as bad as what it was' and 'just put up with it cause she's been here for a long time'. Carmel lost her voice as a result. She had seen her staff health and her GP who had suggested counselling, referred to a speech therapist who had advised the same as this manifestation was as a

result of stress. Carmel had also taken some sick time too. The Head of Midwifery offered to move Carmel to a different team but Carmel declined. At the height of her distressing time she sought the solace of her husband. Another midwife was placed in the team who could be seen to be a problem solver as she had been pivotal in improving Alex's role. The whole experience had upset Carmel and this was obvious as she mumbled and whispered her answers throughout the interview, and her voice only grew stronger towards the end of the interview becoming a normal tone.

Carmel now worked with Toni-midwife, but had also worked with Kate-MSW and midwives Wendy and Rachel. Bridget and I worked a number of months with Carmel before she moved to the northern team and prior this study being undertaken.

Figure 2. Illustration of where MSWs and midwives were working at time of interviews

Community 1

North

Northern Team
MSW Carmel
Midwife Toni

Northwestern Team
MSW Helen
Midwives Hannah & Frankie

West

Training Team
MSW Alex
Midwives Wendy & Rachel

East

Southwestern Team
MSW Gillian
Midwife Heidi

Southern Team
Midwife Bridget (pilot) &
myself (midwife/researcher)

South

Community 2
MSW Kate (pilot)

Appendix 11

Midwifery Support Worker Role Description

JOB DESCRIPTION

POST: Trained Health Care Assistant – Maternity Community Duties

GRADE: Level 11

RESPONSIBLE TO: Team Leader – Senior Midwife 'G' Grade

SUMMARY OF DUTIES: To provide assistance to trained staff by the effective prompt and competent undertaking of delegated duties. To work as part of a team, as directed by the team leader.

DUTIES AND RESPONSIBILITIES OF THE POST

1.   CLINICAL MATERNITY CARE

1.1   Assist with the care of the client's physical and personal needs, ensuring a high standard of care is achieved.

1.2   Assisting midwives in the provision of antenatal care in surgeries or health centres.

1.3   Preparing for the clinic session, assisting the midwife during the clinic and completing the documentation as required.

1.4   Assisting with the client's basic health needs.

1.5   Assisting midwives to meet parents' basic parenting skills/educational needs.

1.6   Chaperone clients while undergoing medial examinations and other procedures if required in a clinic setting.

1.7   Assist with venepuncture.

1.8   Assist in the antenatal care of the mother in the home setting, providing support as necessary for her and her family.

1.9   Assist with postnatal care in the home setting for the mother and her baby, including support with infant feeding, providing education as required.

1.10   In the event of a home birth assist the midwife during the preparation, labour and birth and in the immediate postnatal period.

1.11   In home based care and clinics record clients blood pressure, test urine, measure weight and height and body temperature as delegated by the qualified midwife.

1.12   Document observations made as delegated by the accountable midwife and report findings of significance.

1.13   Collect non-invasive specimens, from clients.

1.14   Assisting with the admission of clients who require this from the clinic or home setting.

1.15   Maintain the clients' rights as an individual, according to the philosophy of Midwifery Care and the Trust's strategic goals.

1.16   Be vigilant to signs of domestic violence or children in need issues.

2.   TRAINING

2.1   Have successfully achieved the relevant National Vocational Qualification, in the appropriate field of direct maternity care.

2.2   Participate in annual performance review with Senior Midwife.

2.3   Attend all mandatory lectures and in-service training as necessary.

2.4   Participate in audit as delegated by the qualified midwife.

2.5   Participate in quality initiatives within the service and on the wider Trust agenda.

2.6   Be aware of fire precautions and equipment in the community settings.

2.7   Have the ability to recognise potential, for challenging health and safety issues e.g. dangerous dogs, hazardous domestic environments, violent situations etc and take appropriate action to alert colleagues and report the situation.

2.8   Willingness to undertake the phlebotomy/venepuncture scope of practice package, maybe a future requirement.

3.   ADMINISTRATION

3.1   Assist with the keeping of routine records, eg, weight, care plan charts.

3.2   Record observations and action on care plans and other clinical records, providing verbal/written reports on the condition of the client to the team leader or named midwife as appropriate.

4.   PERSONAL RESPONSIBILITIES

4.1   Be aware of personal responsibilities as defined in the Health and Safety at Work Act.

4.2   Adhere to hospital policy regarding uniform.

4.3   Maintain confidentially at all times.

4.4   Adhere to all maternity and wider Trust policies and guidelines.

This job description is not intended to be a complete list of duties and responsibilities, but indicates the main ones attached to the post. It may be amended at a future time, after discussions, to take account of changing patterns of midwifery, teaching and management.

Nov 2003

Appendix 12

Copies of Local Research and Ethics Letters

24 August 2006

To Whom It May Concern

SPONSOR'S SELF DECLARATION

Research Project: **Exploring working relationships between midwifery support workers and midwives in** ██████████

Trust Lead: **Mrs Deborah Ellis, Community Midwife**

Project Type: **MPhil/PhD**

On behalf of ████████████ Medical Director, I can confirm ███████
████████████████████ Trust will act as the sponsor for the above research project, and take on the responsibilities of the sponsor as set out in the Department of Health Research Governance Framework for Health and Social Care.

This is conditional upon receiving evidence of ethical approval once granted and the Trust Lead maintaining an accurate and up to date site file of necessary and appropriate documents, which may be inspected by the sponsor at any time.

Yours sincerely

Research Governance Coordinator

30 August 2006

Mrs D Ellis
Community Midwife

Dear Mrs Ellis

Full title of study: **Working Relationships Between Midwifery Support Workers And Midwives**

REC reference number:

Thank you for your application for ethical review, which was received on 29 August 2006. I can confirm that the application is valid and will be reviewed by the Ethics Committee at the meeting on 12 September 2006.

Meeting arrangements

The meeting will be held in the Anaesthetic Seminar Room on 12 September 2006. The Committee would find it helpful if you could attend the meeting to respond to any questions from members. Other key investigators and a representative of the sponsor are also welcome to attend. This may avoid the need to request further information after the meeting and enable the Committee to make a decision on the application more quickly.

If you are unable to attend the meeting, the Committee will review the application in your absence.

The review of the application has been scheduled for 9.00 a.m. I understand you will be attending the meeting, if not could you let me know. Please note that it is difficult to be precise about the timing, as it will depend on the progress of the meeting. We would kindly ask you to be prepared to wait beyond the allocated time if necessary.

Committee meetings are occasionally attended by observers, who will have no vested interest in the applications under review or take any part in discussion. All observers are required to sign a confidentiality agreement.

Documents received

The documents to be reviewed are as follows:

Document	Version	Date
Application	AB	25 August 2006
Investigator CV		
Protocol		01 August 2006
Covering Letter		28 August 2006
Letter from Sponsor		24 August 2006
Questionnaire: Interviews with MSWs	1	01 August 2006
Questionnaire: Interviews with Midwives	1	01 August 2006
Participant Information Sheet	1	01 August 2006
Participant Consent Form	1	01 August 2006
Supervisor CV		

No changes may be made to the application before the meeting. If you envisage that changes might be required, we would advise you to withdraw the application and re-submit it.

Notification of the Committee's decision

You will receive written notification of the outcome of the review within 10 working days of the meeting. The Committee will issue a final ethical opinion on the application within a maximum of 60 days from 30 August 2006, excluding any time taken by you to respond fully to one request for further information or clarification after the meeting.

Research governance approval

You should seek approval from the R&D Department for the relevant care organisation to conduct this research at a NHS site. The research governance approval process may take place at the same time as the ethical review. Final approval from the care organisation will not be confirmed until after a favourable ethical opinion has been given. If you have not already done so, you are advised to contact the R&D Department about their approval process.

Further guidance is available at http://www.rdforum.nhs.uk/links/rdlinks.htm.

Communication with other bodies

All correspondence from the REC about the application will be copied to the research sponsor and the R & D Department for the lead site. It will be your responsibility to ensure that other investigators, research collaborators and NHS care organisation(s) involved in the study are kept informed of the progress of the review, as necessary.

Yours sincerely

███████████████

Committee Co-ordinator

Enclosure: Further information about REC membership and meeting arrangements

Copy to:

12 September 2006

Mrs D Ellis
Community Midwife
████████████████████████████ NHS Foundation Trust
Community Midwifery Office
████████████████████

Dear Mrs Ellis

Full title of study: **Working Relationships Between Midwifery Support**
                                  Workers And Midwives
REC reference number: ███████████

The Research Ethics Committee reviewed the above application at the meeting held on 12 September 2006.

Ethical opinion

The members of the Committee present decided that it was unable to give a favourable ethical opinion of the research, for the following reasons:

There was inadequate information on the application form to enable the Committee to fully review this study. As written at present the Committee thought this project appeared to be more in the category of service evaluation than research.

If you intend to re-apply below are several points the Committee felt you may wish to consider.

The title does not fully explain the project to add something along the lines of "To explore", would give more explanation of your ideas.

You gave very little information on the background of the study you should explain (as you did in the meeting) the reasons for reviewing ████████ and not other areas. Giving more detailed methodology and the justification for undertaking the research.

As discussed you may wish to consider researching an additional area (such as ████████) to allow comparison.

At A10 Much more information is again required; the Committee need to understand the reasons for using the methods of analysis of information from the focus group. How you will test emerging theories in later interviews.   Explain in more detail how you will use the voice centred relationships approach and reflexivity to gain information from the focus groups.

The Committee were concerned recruitment could be a problem again this should be addressed in the application as it was in the meeting. In addition, coercion and bias may be an issue here if you work closely with participants, this area should be acknowledge and the steps taken to minimise it explained. It is not good practice to carry out this kind of qualitative research within your own team.

The Interview schedules you presented differed, you should change the proposed questions to Midwifery Service Assistants to better explore their relationship with the Midwives, along the lines of your questions to Midwives.

At ▮▮▮▮▮▮▮▮▮▮▮▮ recommend that data are kept for one year after completion of the study, the qualification is award or results published, whichever is the later.

The Committee likes to see the written comments made at peer review.

You should explain briefly how much funding you have received and what it will be used for.

In its present form the ethics committee is unable to approve your project. We hope you will take into account our comments and find them useful. If you have any questions please get in touch.

Options for further ethical review

You may submit a new application for ethical review, taking into account the Committee's concerns. You should enter details of this application at Question A55 on the application form and include a copy of this letter, together with a covering letter explaining what changes have been made from the previous application.

Alternatively, you may appeal against the decision of the Committee by seeking a second opinion on this application from another Research Ethics Committee. The appeal would be based on the application form and supporting documentation reviewed by this Committee, without amendment. If you wish to appeal, you should notify the Central Office for Research Ethics Committees (COREC) in writing within 90 days of the date of this letter. If the appeal is allowed, COREC will appoint another REC to give a second opinion within 60 days and will arrange for the second REC to be provided with a copy of the application, together with this letter and other relevant correspondence on the application. You will be notified of the arrangements for the meeting of the second REC and will be able to attend and/or make written representations if you wish to do so.

The relevant COREC contact point is:

▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮

Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date
Application	AB	25 August 2006
Investigator CV		
Protocol		01 August 2006

Covering Letter		28 August 2006
Letter from Sponsor		24 August 2006
Questionnaire: Interviews with MSWs	1	01 August 2006
Questionnaire: Interviews with Midwives	1	01 August 2006
Participant Information Sheet: PIS	1	01 August 2006
Participant Consent Form: CF	1	01 August 2006
Supervisor CV		

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

███████	**Please quote this number on all correspondence**

Yours sincerely

Vice-Chair

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

Copy to:

07 November 2006

█████████

████████████
████████████
████████████

Dear Mrs Ellis

Full title of study: **Exploring Working Relationships Between Midwifery Support Workers And Midwives In█████████ Community**

REC reference number: ████████

The Research Ethics Committee reviewed the above application at the meeting held on 07 November 2006. Thank you for attending to discuss the study.

Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date
Application	████	21 October 2006
Investigator CV		
Protocol	2	
Covering Letter		24 October 2006
Letter from Sponsor		24 August 2006
Interview Schedules/Topic Guides		
Participant Information Sheet	1	01 August 2006
Participant Consent Form	1	01 August 2006
Interview Schedule	2	01 August 2006
Interview Schedule	2	01 August 2006
Supervisor CV		
Unfavourable Letter		12 September 2006
Peer Review		31 October 2006

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

████████   **Please quote this number on all correspondence**

Yours sincerely

████████

Vice-Chair
████████**ocal Research Ethics Committee**
(Reviewed by e-mail)

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments.

Copy to: ████████

13 December 2006

███████████

████████████
████████████
████████████

Dear Mrs Ellis

Full title of study: **Exploring Working Relationships Between Midwifery Support Workers And Midwives In** ██████████ **Community**

REC reference number: ████████

Thank you for your letter of 02 December 2006, responding to the Committee's request for further information on the above research.

The vice-chair of the ████████ Local Research Ethics Committee considered the further information on 12 December 2006.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for other Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application	████████	21 October 2006
Investigator CV		
Protocol	2	
Covering Letter		24 October 2006
Letter from Sponsor		24 August 2006
Interview Schedules/Topic Guides		
Participant Information Sheet	1	01 August 2006
Participant Consent Form	1	01 August 2006
Response to Request for Further Information	V1	02 December 2006
Interview Schedule	2	01 August 2006
Interview Schedule	2	01 August 2006
Supervisor CV		
Unfavourable Letter		12 September 2006

Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

████████	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

████████

Chair

Enclosures: Standard approval conditions

Copy to: ████████████████████